A STUDY TO ASSESS THE EFFECTIVENESS OF INFORMATION, EDUCATION AND COMMUNICATION PACKAGE IN TERMS OF KNOWLEDGE AND KNOWLEDGE ON PRACTICE REGARDING LIFESTYLE MODIFICATION AMONG ANAL FISSURE PATIENTS IN ASHWIN HOSPITAL, COIMBATORE

By

Reg. No: 301311104

A DISSERTATION SUBMITTED TO THE TAMIL NADU Dr. M. G. R. MEDICAL UNIVERSITY, CHENNAI IN PARTIAL FULFILLMENT OF REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

OCTOBER 2015

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EXTERNAL **INTERNAL**

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Dedicated to
Almighty God,
Lovable Parents,
Brother, Sister
& Friends

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CHAPTER - I

Introduction

"Teaching is only demonstrating that it is possible.

Learning is making it possible for yourself"

- Paulo Coelho

There are several very painful experiences that one suffers in stillness as it is a discomforting topic to be even discussed. Anal fissure is such a common occurrence in adults but is very rarely talked about because of the embarrassing nature of the condition. Many people are even too embarrassed to see about anal fissure. Nearly every patient visiting the general or colon and rectal surgeon with anal problems comes in complaining of anal fissure. They are often assigned blame for purities ani, hemorrhoids, condylomata acuminate, fistula in ano and incontinence. Treatment for anal fissure is only needed if they are truly symptomatic. The mere presence of anal fissure is not an indication for any therapeutic intervention (World Health Organization, 2011).

An anal fissure is a break or tears in the skin of the anal canal (a terminal part of the large intestine). And the most common sign and symptom of anal fissures is bright red anal bleeding on toilet paper, sometimes in the toilet. It is of two types acute and chronic, acute anal fissure may cause pain at the time or after defecation. Anal fissures generally extend from the anal opening and are located posterior, because anal wall has unsupported nature and poor perfusion in that location (Brunner and Suddarth, 2011).

Moreover, anal fissure is one of the most common anal problems. Anal fissure is related with increased anal sphincter pressures and most useful treatment is based on the reduction of anal pressure. Still some of the moderate management that is to increase fiber in diet and warm baths which can heal approximately half of all anal fissures and the fissures that fail in these conservative managements, various pharmacologic and surgical options are there which provides satisfactory cure rates. Therefore it is important to assess the early sign and symptoms of the condition and to encourage moderate management (World Health Organization, 2011).

Lewis. S. M (2011) categorized anal fissure as acute or chronic. Acute fissures present with anal pain, spasm, and/or bleeding with defecation. The diagnosis can be confirmed by physical examination and endoscopy in the office if tolerated by the patient. By gentle separation of the buttocks and examination of the anus, a linear separation of the endoderm can be identified at the lower half of the anal canal. Approximately 90% of anal fissures in both men and women are located posteriorly in the midline. However, The fissures may be associated with Crohn syndrome, sexually transmitted diseases (human immunodeficiency disease [HIV], syphilis, or herpes), anal cancer, or tuberculosis. The acute fissures commonly heal with medical management after 4 to 6 weeks, chronic fissures persist beyond 6 weeks.

Amarjeet Singh (2011) stated that chronic fissure can be assessed by the presence of indurate edges, visible internal sphincter fibers at the base of the fissure, a sentinel polyp at the distal end of the fissure or a fibro epithelial polyp at the apex. A chronic fissure classically occurs at the posterior midline position (6 o'clock position), with the anterior midline position occurring in 10% of females and 1% of males. Fissures occurring at positions other than the 6 o'clock position or the presence of

multiple fissures may suggest other pathologies like tuberculosis, inflammatory bowel disease, syphilis and immunosuppressive diseases like Human immunodeficiency virus.

Nelson. R (2015) reported that superficial or shallow anal fissures looks like a paper cut, and may be hard to detect on visual inspection, they will generally self-heal within a couple of weeks. In adults, fissures may be caused by constipation, the passing of large, hard stools, or by prolonged diarrhea. In older adults, anal fissures may be caused by decreased blood flow to the area. In contrast, fissures are found laterally, tuberculosis, occult abscesses, leukemic infiltrates, carcinoma, acquired immunodeficiency syndrome (AIDS) or inflammatory bowel disease should be considered as cause. Furthermore, Anal dilation is one of the common methods of treating anal fissures. This was one of the most knowing and accepted methods of treating the anal fissures.

Michael. A (2012) stated that acute anal fissures have sharply distinguished, fresh mucosal edges, often with formation of tissue at the base. Acute fissures are believed to often heal spontaneously. Chronic anal fissures: Fissures persisting for longer than 4 weeks, or recurrent fissures, are generally defined as chronic. Chronic anal fissures have distinct anatomical features, such as visible sphincter fibres at the fissure base, anal papillae, sentinel piles, and hard margins. Most published studies only require the presence of one of these signs or symptoms of long duration (chronicity) to classify a fissure as chronic.

The cause of anal fissure is not fully understood. Low intake of dietary fibre may be a risk factor for the development of acute anal fissure. People with anal fissure often have raised resting anal canal pressures with anal spasm, which may give rise to decrease in blood supply to the tissues (George G. Zainla, 2012).

Das. S. A (2011) stated that chronic anal fissure is a common and painful condition associated with internal anal sphincter rigidity. Reduction of this increased rigidity improves the local blood supply, encouraging fissure healing. Surgical sphincterotomy is very successful at healing these fissures but requires an operation with associated morbidity. Temporary reduction in sphincter tone can be achieved on an outpatient basis by applying a topical nitric oxide donor (for example, glyceryl trinitrate) or injecting botulinum toxin into the anal sphincter.

Chronic anal fissure is a common benign disorder that causes severe, sharp anal pain at the time of passing stool. Fissures are generally associated with raised resting anal pressures, and treatments are aimed at reduction of these pressures (Gomez Cedenilla, 2012).

Mc Callion. K (2015) stated that acute fissures may heal spontaneously, although simple conservative measures are sufficient. Chronic anal fissures of unknown cause need careful evaluation to decide what therapy is suitable. Pharmacological agents such as glyceryl trinitrate (GTN), diltiazem and botulinum toxin have been subjected to most careful examination. Though practices regarding lifestyle changes are quite important for the clients to follow. Lifestyle changes may lead to sufficient and satisfactory outcomes to resolve anal fissure.

Aziz. A (2013) reported current treatment of chronic anal fissure is based on conventional conservative measures in a high percentage of cases. Chemical sphincterotomy achieves a temporary decrease of anal pressures that allows fissures to heal. There are various alternatives such as nitroglycerine or diltiazem ointment and botulinum toxin injections. Chemical sphincterotomy should be the first option in

patients with a high risk of incontinence. "Open" or "Closed" lateral internal sphincterotomy performed in the ambulatory setting with local anesthesia can currently be considered the ideal treatment of chronic anal fissure.

Robledo. P (2012) stated that the diagnosis of chronic anal fissure is easy and common in clinical practice. Little is known about the causes and process of occurrence of this disorder. Current investigations consider anal sphincteric rigidity and lack of blood supply to the anal tissues as primary factors in the appearance and maintenance of the lesion. Conservative measures to avoid constipation, including fiber intake, are useful to improve signs and symptoms, achieve healing, and reduce recurrence.

Sanju Dhawan (2013) stated that the disability associated with surgery for anal fissure and the risk of incontinence, medical alternatives for surgery have been sought. Most recently, conservative measures and pharmacologic methods that relax the anal smooth muscle, to accomplish reversibly what occurs in surgery, have been used to obtain fissure healing.

Need for the Study

WHO (2014) stated that now a days there is very competitive lifestyle. Because of ultimate eating, sleeping, working, lack of exercise and more intake of junked, baked food etc. has made man to suffer from a lots of health problems. Anal fissure is one of them, a simple but very painful condition. Hence the researcher selected t for the research.

Aanal fissure is the most painful anal disease which affects both sexes equally; it is more common in youngsters. Acute anal fissure if fails to heal then it gradually develops in to chronic anal fissure (American Medical Society, 2013).

Anal fissures are very common at any age. The rate of anal fissures drops with age. In adults, fissures may be caused by passing large, hard stools, or by having diarrhea for a long time. Other factors are decreased blood flow to the area in older adults, too much tension in the sphincter muscles that control the anus; anal fissures are also common in women after childbirth and in persons with Crohn's disease (Ayantunde. A, 2015).

Danakas. G (2013) stated that fissures are commonly caused by trauma to the inner lining of the anus. Patients with tight anal sphincter muscles (i.e., increased muscle tone) are more prone to developing anal fissures. A hard, dry bowel movement is typically responsible, but loose stools and diarrhea can also be the cause. Following a bowel movement, severe anal pain can produce spasm of the anal sphincter muscle, resulting in a decrease in blood flow to the site of the injury, thus impairing healing of the wound.

Fissures can recur easily, and it is quite common for a fully healed fissure to reoccur after a hard bowel movement or any other trauma. Even when the pain and bleeding have subsided, it is very important to continue good bowel habits and a diet high in fiber as a lifestyle change. If the problem returns without any exact cause, further assessment is needed (García Granero. E, et.al., 2015).

It is important to note that complete healing with both medical and surgical treatments can take up to approximately 6-10 weeks. However, acute pain after surgery often disappears after a few days. Most patients will be able to return to work and resume daily activities in a few short days after the surgery (Parker. M. C, 2015).

It is estimated that about 75 percent of people will have hemorrhoids at some point in their lives if ignored increase the risk of getting anal fissure. Hemorrhoids are most common among adults ages 45 to 65 and also common in pregnant women; they become large and cause problems in only 4% of the general population. Hemorrhoids that cause problems are found equally in men and women, and their prevalence peaks between 45 and 65 years of especially with mild hemorrhoids which finally leads to anal fissure (American Medical Association, 2013).

Jonas. L, et.al., (2012) stated that without early diagnosis and treatment, an acute episode of constipation can lead to anal fissure and may become chronic. Early identification of constipation and effective treatment can improve outcomes for client. The guideline provides strategies based on the best available evidence to support early identification, positive diagnosis and timely, effective management. Implementation of the guideline will provide a consistent, coordinated approach and will improve outcomes for clients. Anal fissures are a common cause of anal pain during, and for 1 to 2 hours after, defecation. The cause is not fully understood, but low intake of dietary fiber may be a risk factor.

Anal fissure is a common and distressing problem, the true incidence of which is probably higher than recorded. Most anal fissures heal with medical therapy, but

their limitations include side effects, poor compliance, and recurrence of the fissure (Sajid. M. S, 2013).

The investigator from his personal experience during his clinical posting identified that most of the patients with anal fissure admitted in hospital were not aware of the various risk factors leading to anal fissure and complications which could have been easily prevented if they have adequate knowledge about and have a positive practice towards anal fissure. So the investigator conducted a study to assess the effectiveness of information education and communication package in terms of knowledge and knowledge on practice regarding lifestyle modification among anal fissure patients.

Statement of the Problem

A study to assess the effectiveness of Information Education and Communication package in terms of Knowledge and Knowledge on Practice regarding Lifestyle modification among Anal Fissure patients in Ashwin Hospital, Coimbatore.

Objectives

- To assess the knowledge and knowledge on practice of lifestyle modification among the patients with anal fissure.
- To deliver Information, Education and Communication package among patients with anal fissure regarding life style modification.
- To evaluate the effectiveness of Information, Education and Communication package on knowledge and knowledge on practice regarding life style modification among anal fissure patients.

- To find out association between selected demographic variables with knowledge and knowledge on practice regarding lifestyle modification of patients with anal fissure

Hypothesis

H_1 There is a significant difference in the pre test and post test Knowledge and knowledge on practice score of anal fissure clients related to lifestyle changes after the Information, Education and Communication package.

Operational Definitions

Assess

It refers to the Organized, systematic and continuous process of collecting data from the clients having anal fissure.

Effectiveness

It refers to the improvement in knowledge and knowledge on practice regarding life style modification among fissure clients after the implementation of IEC package evidenced by the differences in the pretest and post test scores.

Information Education and Communication Package

It refers to sharing of information and ideas regarding life style modification to the clients who are suffering from anal fissure by teaching with the help of power point presentation and distribution of pamphlets.

Knowledge

It refers to the amount of information the patient with anal fissure possess about lifestyle modification, which is explored by the knowledge questionnaire.

Knowledge on Practice

It refers to the knowledge on day today action of patient with anal fissure on lifestyle modification, which explore by the score of knowledge on practice questionnaire.

Lifestyle Modification

In this study the term lifestyle modification can be used to refer the interventions that attempt to create change in multiple lifestyle health behaviors.

Anal Fissure

A break in the skin, usually where it joins a mucous membrane, producing a crack like sore or ulcer.

Assumptions

- Patients with anal fissure have inadequate knowledge regarding lifestyle modifications.
- The knowledge of patients in lifestyle modification in anal fissure influence knowledge on practice.
- A Information Education and Communication package may enhance the knowledge and knowledge on practice on lifestyle changes among patients having anal fissure.

CHAPTER - II

Review of Literature

Review of literature is the key step in the research process. It refers to an extensive, exhaustive and systematic examination of publications relevant to the research project (Polit and Hungler, 2004).

A literature review helps to lay the foundation for a study and can also inspire new research ideas. It can help with orientation to what is known and not known about an area of inquiry, to ascertain what research can best make a contribution to the existing base of evidence. Literature review throws light on the studies and findings reported about the problems under the study.

The Related Review of Literature has been Organized under the Following Headings

- Literature related to overall view of anal fissure and it's management
- Literature related to effectiveness of information, education and communication programme regarding lifestyle modification among patients with anal fissure.

Literature Related to Overall View of Anal Fissure and it's Management

Kabin. G. Meteda (2013) stated that anal fissure is a small break or tear in the skin of the anal canal, which typically runs from below the dentate line to the anal verge, and is usually situated in the posterior midline. Anal fissure may be acute or chronic. Individuals will experience anal pain as predominant symptom. During

defecation pain may last for several minutes to hours or the entire day like knife cutting.

An Indian study on incidence of anal fissure states that 1 in every 200 population suffering from minor or major type of this ailment and one third among this will suffer from various complications at any term of their life (Bhardwaj. R, 2015)

Shao. W. J (2011) conducted a study in India, regarding the incidence and prevalence of anal fissure, it is found that approx 1 in 26 or 3.82 percent or 10.4 million people have anal fissure in India. Prevalence of anal fissure increases with age and peaks in people aged 45-65 years. According to the same statistics (1983-87) the Mortality: 17 deaths, Hospitalizations: 316, 000, Physician office visits: 3.5 million, Prescriptions: 1.5 million, Disability: 52,000 people.

Hans. P. A, et.al., (2013) conducted a study regarding the prevalence of anal fissure, in which the clinical records of 835 patients were reviewed. Five hundred ninety four had primary symptoms of anal fissure and 241 had secondary symptoms anal fissure. Eight-six per cent of the entire group, 88 per cent among the primary symptoms and 82 per cent among the secondary symptoms had anal fissure.

Rebecca Waller (2010) conducted a study in Australia among women to identify the prevalence of constipation and its effect and the result shows that prevalence of constipation is 14.6% in young women and 26.6 % in middle aged women and 58% in older women and most number of fissure anal cases were found among older women.

The cause of anal fissure is not fully understood. Low intake of dietary fibre may be a risk factor for the development of acute anal fissure. People with anal fissure often have raised resting anal canal pressures with anal spasm, which may give rise to decrease in blood supply to the tissues (George. G, 2012).

Bhardwaj. R (2015) stated that acute anal fissures have sharply distinguished as superficial fissure and deep fissure. Superficial fissure have a morphology of severe pain with or without bleeding, superficial separation of the anoderm with sharp edge, base of the fissure does not reach the internal anal sphincter, vast majority heal spontaneously within days or within weeks of appropriate conservative treatment. Deep fissure are often visible fibers of the internal anal sphincter, minimal granulation tissue at the base, wide pear shaped ulcer, triad of indurated ulcer edges. Often persist and either tend not to heal without intervention or recur regularly.

Abhishek Sharma (2011) study conducted in Nagpur, India regarding Consumption of red-hot chili pepper increases symptoms in patients with acute anal fissures and Hemorrhoids reveals that Consumption of chili does increase the symptoms of acute anal fissure and hemorrhoids**.**

Batterman (2010) anal fissures present with anal pain, spasm, and bleeding with defecation. The diagnosis can be confirmed by physical examination and endoscopy in the office if tolerated by the patient. By gentle separation of the buttocks and examination of the anus, a linear separation of the endoderm can be identified at the lower half of the anal canal. The anal fissures commonly heal with medical management after 4 to 6 weeks, chronic fissures persist beyond 6 weeks.

Lt. Col. S. Melhotra (2009) stated that anal fissures have the symptoms of anal pain, bleeding, bright red anal bleeding on toilet paper, sometimes in the toilet. It is of two types acute and chronic, acute anal fissure may cause pain at the time or after defecation. Anal fissures generally extend from the anal opening and are located posterior.

Dunning. T (2012) stated that anal fissures are look like oval shaped ulcer in the squamous epithelium of the anal canal. Anal fissures may be caused by decreased blood flow to the area. In contrast, fissures are found laterally, tuberculosis, occult abscesses, leukemic infiltrates, carcinoma, acquired immunodeficiency syndrome (AIDS) or inflammatory bowel disease should be considered as cause. Furthermore, Anal dilation is one of the common methods of treating anal fissures.

Minguez. M (2015) conducted a study in united kingdom among cohort patient evaluated by colorectal surgeon explains that even though commonly associated with rectal bleeding, hemorrhoids may thrombose and cause intense anal pain and swelling. In this study, they prospectively assessed risk factors for thrombosed hemorrhoids in a cohort of patients evaluated by colorectal surgeons. Study has concluded that swelling as the primary complaint of patients with anal fissure. Independent risk factors for thrombosed anal fissure include age younger than 40 and history of dietary pattern.

Jensen. S. L (2012) surgical excision of sphincter and fibrous polyp relieves symptoms and offers good healing for anal fissure. It has been described as initial modes of treatment in anal fissure. There are various management for anal fissure

among that Non operative is the first line management both in acute and chronic anal fissure. Half of all patients of acute and chronic anal fissure will heal with non operative measures. Late recurrence is higher (about 50%) with non operative treatment associated with pain and bleeding (Pfenninger, 2012).

Scholedfield (2014). stated that non operative management treats both initiating and perpetuating factors concurrently. It includes dietary advice, medication, biofeedback, perineal support, Manual and Modified toilet seat, sitz baths and topical preparations.

Carapeti. E. A (2012) conducted a randomized study, treatment with 10g of unprocessed bran twice daily and warm sitz baths for 15 minutes twice daily and after each bowel movement resulted in symptomatic relief and better healing at 3 weeks (88%) compared with 2% lignocaine ointment or 2% hydrocortisone cream 31.32. In another randomized prospective study, treatment with 15 g of unprocessed bran in three divided doses daily was shown to have significantly fewer recurrences (16%) compared with patients receiving 7.5 g of bran daily (60%) .

Buse. W. D (2011) conducted a study on high anal pressure. Several studies have investigated the effect of topical glyceryl trinitrate ointment. Healing rates range from 30% to 86%. Therapy is limited because of a high incidence of moderate to severe headaches up to 84% of patients. Comparable results are observed after injection of botulinum toxin into the anal sphincter (43-96%). Minor incontinence for flatus and soiling has been reported in up to 12% of patients. Further pharmacological approaches including treatment via calcium channel blockade and treatment with alpha-adrenoceptor antagonists are still at a developmental stage.

Nuchel. J (2013) conducted a comparative study, total 30 patients, 15 patients in each group. First 15 patients were treated with 2% diltiazem gel and other 15 patients were treated with 0.1% bethanechol gel three times daily for eight weeks. Assessment was done every 2 weeks by clinical examination, repeat anal manometry, and laser Doppler flowmetry. And daily pain was assessed by linear analog charts. Results has shown that the fissure healed in 10 of 15 (67%) patients who were treated with 2% diltiazem gel and 9 of 15 (60%) patients treated with 0.1% bethanechol gel. It has found that there was reduction in the pain score after treatment with diltiazem and bethanechol compared with previous treatment.

Antonio (2013) conducted an experimental study on botulinum toxin injection. The research has done on total 150 patients with chronic anal fissure. They were treated with 20– 30 units of botulinum toxin injection. The result showed 89–96% healing rates at 6-8 weeks with 4% recurrence rates 23. In a study done in 2009, 30 patients with anal fissure were treated with botulinum toxin. The results showed a healing rate of 93.3% and pain relief of100% after 3 month.

Tariq Wahab (2013) conducted a descriptive study on total of 146 patients with lateral internal sphincterotomy. The 140 patients out of 146 patients had completed healing of fissure by the end of 3 months. Out of 140 patients there were 124 patients who have healed fissure within 6 weeks, remaining 12 patients healed within 7 weeks and the other 4 patients have healed by the end of 3 months. Therefore, the overall healing rate was 97.5%. On the other hand 4.1% has experienced transitory flatus incontinence.

Gupta. P (2012) conducted a study on 45 patients suffering from chronic anal fissure underwent the procedure of internal anal sphincterolysis. 36 (79.5%) patients were highly satisfied with the procedure. While another 9 (16%) patients rated the procedure as Good. Study concluded anal sphincterolysis is a safe effective and easy procedure which achieves good symptom control.

Nelson. R. L (2015) conducted comparative study on two groups that is open sphincterotomy group and botulinum toxin group. Total of 80 patients were treated, 40 patients were treated with open sphincterotomy and 40 with botulinum toxin injection and observed that the healing rate in open sphincterotomy group was 92.5% and in botulinum toxin group healing rate was 45%. The final percentage of incontinence was 5% in open sphincterotomy group and 0% in botulinum toxin group. Menon G R (2013) done a systemic review to assess continence at two years or more after lateral internal sphincterotomy (LIS) for chronic anal fissure (CAF). 324 studies were screened, 22 were included. The follow-up period continued for 24-124 months. The overall continence disturbance rate was 14%. Then analysis showed flatus incontinence in 9%, seepage in 6%, accidental defecation in 0.91%, incontinence to liquid stool in 0.67% and incontinence to solid stool in 0.83% of patients.

Manik. C (2011) fissures are generally associated with raised resting anal pressures, and treatments are aimed at reduction of these pressures. Recurrence rate after healing is high, so anal fissure may be a chronic disease that evolves depending on sphincteric features lifestyle modification are necessary in order to prevent these complication. Conservative measures to avoid constipation, including fiber intake, are useful to improve signs and symptoms, achieve healing, and reduce recurrence.

Health care information should encompass in all aspects of keeping a person in a state of health.

Literature Related to Effectiveness of Information, Education and Communication Programmes Among Patients with Anal Fissure

Information education and communication package refers to sharing of information and ideas regarding life style modifications of the clients by explaining with the help of power point presentation and distribution of pamphlets or booklets. Combination of educational methods will effectively enhance the knowledge, attitude and practice of the clients.

Tinay. E. E (2011) conducted a study to assess the knowledge and practice of 121 anal fissure patients. Data was collected by using questionnaire and physical examination results showed that the lifestyle modification among patient with anal fissure was low and some patients had incorrect practice towards lifestyle management.

Davin. K (2013) conducted a study to assess the effectiveness of a multi faceted IEC programme on lifestyle modification of anal fissure. Patient attended four educational units held by the researcher. The result of the study showed patients knowledge level was improved significantly regarding the lifestyle modification.

Brusen (2012) conducted a similar study to assess the effectiveness of structured teaching programme on lifestyle modification of patient with chronic anal fissure. The subjects are provided with repeated health education sessions and book

let distribution about the lifestyle changes. After the intervention it was found that the knowledge and practice of the patients on life style changes was improves significantly.

Alex Tudor (2013) studied on the benefits of an IEC programme on lifestyle modification among patients with anal fissure. The programme was performed among 90 patients with anal fissure. The patients knowledge level was determined by using knowledge and practice questionnaire. The study results showed that after the programme, the patient's knowledge and practice regarding lifestyle modification was improved significantly. Researcher concluded that the IEC programme was effective in increasing the knowledge and practice regarding of patients with anal fissure.

A study conducted by Donald (2011) to assess the knowledge and practice on lifestyle modification on anal fissure. It revealed that the knowledge level is correlated to the practice level on management of anal fissure. The study showed that when knowledge score increased, the practice score was also increased moderately.

Sajid. M. S (2013) conducted a study to find out the effectiveness of an Self instruction module on knowledge and practice among patients with anal fissure. 100 newly diagnosed patients with anal fissure between the age group of40 and 60 were selected by convenient sampling method and Self instruction module was executed by using structured teaching and educative booklets. The study results revealed that the mean knowledge and practice were significantly improved after the programme and concluded that the Self instruction module was very effective.

Jstun Kemop (2011) conducted a study among 50 patients with chronic anal fissure regarding the knowledge about self care management. Investigator used demographic questionnaire, self care agency, scale and self care questionnaire, to assess the knowledge regarding self care management of anal fissure. After the study it was found that the experimental group is having significant increase in the knowledge regarding the self care management about chronic anal fissure.

Chang. T. Y (2012) conducted a study to develop a scale to measure knowledge about lifestyle modification of patient with anal fissure. The Knowledge-level scale was generated based on content, face, and construct validity, internal consistency, test re-test reliability, and discriminative validity procedures. There is a significant relationships were found between knowledge on lifestyle modification and age, gender, educational status and family income.

Dundar. P. E (2011) conducted a study regarding the knowledge and practice on lifestyle modification among anal fissure patients in developing countries. The study result reveled that there was a correlation between the knowledge and practice. The practice of patients towards lifestyle modification had significant relationship with age and educational status of the patients.

Conceptual Framework

Concept is a complex mental formulation of object, property of event that is defined from individual perceptual experience. Conceptualization is a process of forming ideas, which are utilized, and forms conceptual framework for development of research design. It helps the researcher to know what data need to be collected and gives direction to an entire research process. The investigator adopted the modified conceptual framework based on the concept of "Kings Goal Attainment Theory" by Imogene King (1971). According to Imogene King "If nurses are to assume the role and responsibilities expected of them, the discovery of knowledge, the system as a whole and all activities can be resolved into aggregation of circuits such as interaction, perception and transaction".

Reaction

It refers to an action taken in response to something. In this study reaction includes assessment of knowledge by using structured knowledge and knowledge on practice questionnaire (Pre test). Here, the researcher finds out the existing knowledge on practice of anal fissure patients regarding anal fissure, management, complication drugs and exercise.

Interaction

It is a process of perception and communication between person and environment and between person and person represented by verbal and non-verbal behaviours that are goal- directed. In this study, the nurse investigator interacts with the anal fissure patients and administers the IEC package to the anal fissure patients immediately after pretest.

Transaction

It refers to the purposeful interactions that lead to goal attainment. In this study, the researcher reassesses the knowledge and knowledge on practice of anal fissure patients regarding anal fissure, management, complication drugs and exercise.

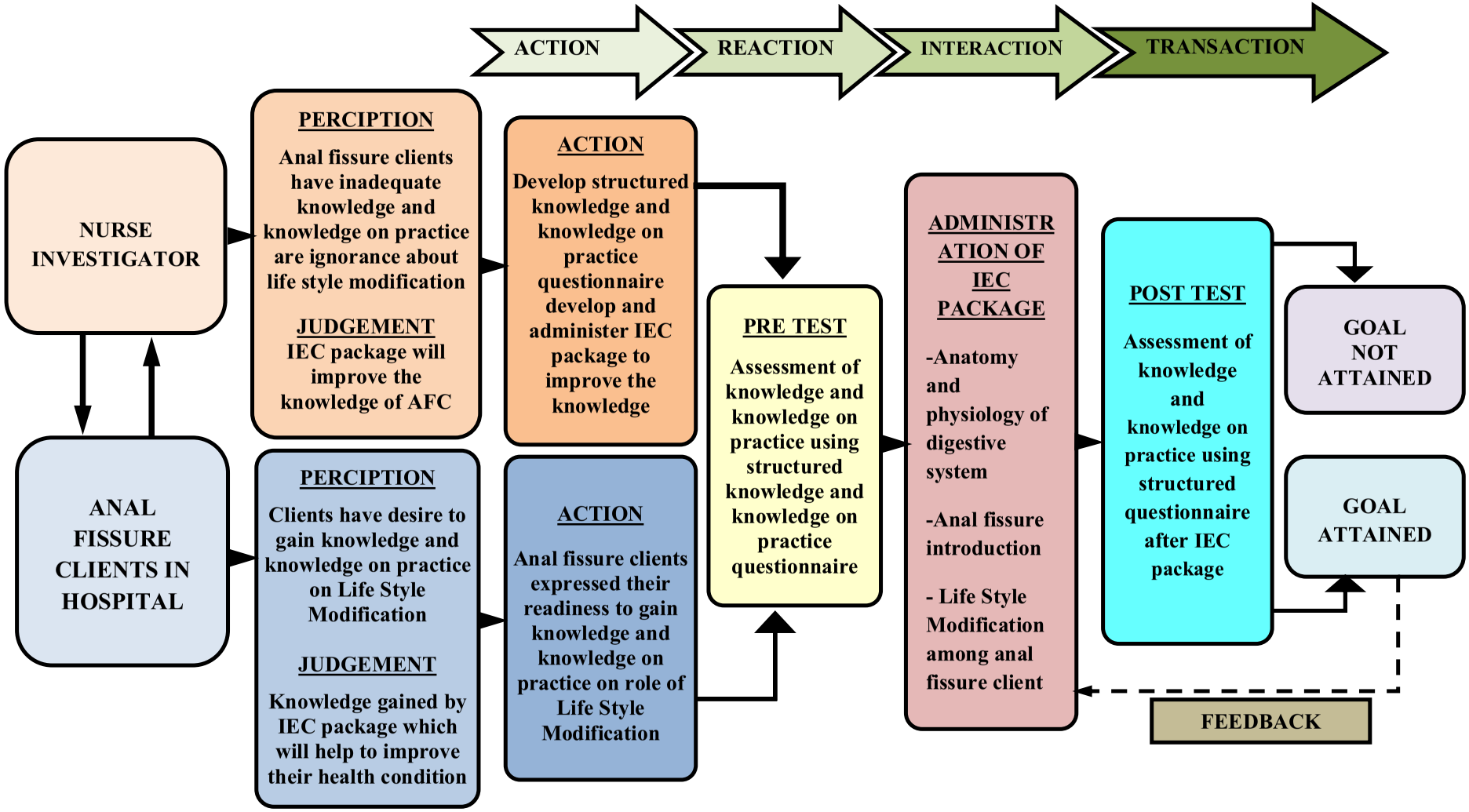

Figure. 1 Modified Conceptual Framework Model on Imogene King's Goal Attainment Model (1971)

CHAPTER – III

Methodology

This chapter includes research approach, research design, setting o the study, population, sample size and sample technique, criteria for the selection of the sample, description of the tool, testing of tool, pilot study, data collection procedure and plan for data analysis.

Research Approach

Quantitative approach was adopted in this study. This study was aimed at assessing the knowledge and knowledge on practice regarding lifestyle modification of patients with anal fissure.

Research Design

The research design adopted for the present study was one group pre-test post test, pre- experimental design.

$$O_1 \qquad X \qquad O_2$$

O_1 Pre-test level of knowledge and knowledge on practice regarding lifestyle modifications among patients with anal fissure clients.

X Information, Education and Communication Package about Anal fissure

O_2 Post-test level of knowledge and knowledge on practice regarding lifestyle modifications among patients with anal fissure.

Setting of the Study

The study was conducted in Ashwin hospital, Coimbatore which is a 350 bedded Multispecialty Hospital, situated 7 Km away from PPG College of Nursing, Coimbatore.

Variables

The independent variable was Information, Education and Communication package about the anal fissure. The dependent variables were the knowledge and knowledge on practice regarding anal fissure. The influencing variables were demographic variables which include age, gender, education status, occupation status, Income of the family, type of family, marital status, religion, dietary pattern, social habits, exercise pattern, previous information regarding anal fissure and family history

Figure.2 The schematic representation of research variables

Population

The population of the study includes the patients with chronic anal fissure, admitted in Ashwin Hospital during the period of data collection.

Sample Size

The sample size of the study was 50.

Sampling Technique

In this study Non probability convenient-sampling technique was used for selecting the samples in the present study.

Criteria for the Selection of Samples

Inclusion Criteria

- Patients with age above 20 years.
- Both male and female patients who are admitted in medical and surgical ward
- All the adult patients diagnosed with chronic anal fissure.
- Patients who are available at the time of data collection.
- Patients who knows Tamil and English.

Exclusion Criteria

- Patients with acute anal fissure.
- Fissure manifested in other systemic diseases (Ex: inflammatory bowel disease, anal cancer, tuberculosis).
- Patient who are not willing to participate.
- Patients who are selected for pilot study.

Description of the Tool

The researcher had developed questionnaire after Review of Literature to assess the knowledge and knowledge on practice of patients with anal fissure.

Section - A Demographic Variables

Demographic variables which include age, gender, education status, occupation status, Income of the family, type of family, marital status, religion, dietary pattern, social habits, exercise pattern, previous information regarding anal fissure and family history.

Section - B Knowledge Questionnaire

It consist of 25 multiple choice questions to assess the knowledge of patients on Anatomy and Physiology of gastrointestinal tract, anal fissure, management and lifestyle modifications. Each item consisted of 4 options in which 1 option was most appropriate. The participants were asked to read the questions and mark the appropriate option. Every correct answer was awarded 1 score and 0 score for incorrect answer. The possible maximum score is 25 and minimum is 0.

Section - C Knowledge on Practice Questionnaire

It consists of 15 statements to assess the knowledge on practice regarding lifestyle modification, diet, exercise, follow up care. Both positive and negative score were formed and score was assigned based on yes or no questions. The maximum score is 15 and minimum is 0.

Testing of the Tool

Content Validity

The tools was given to the five experts in the field of nursing and medicine for content validity. All the comments and suggestions given by the experts were duly considered and corrections were made.

Reliability

Spearman's split half method was adopted to make the reliability of the tool. The r value was 0.92 For knowledge questionnaire and 0.94 for knowledge on practice questionnaire.

Pilot Study

It was conducted among 6 patients for a patients or a period of one week at Ashwin Hospital, Coimbatore. After getting permission from Medical Director, pretest and post test was conducted by using the knowledge questionnaire and knowledge on practice statement. The pilot study report showed that there was an increase in the knowledge and knowledge on practice towards lifestyle modification among anal fissure patients. It was found to be appropriate and feasible to conduct the main study.

Data Collection Procedure

The formal permission was obtained from the Chairman of Ashwin Hospital to conduct study. The study was conducted for a period of month from 02-01-2015 to 31-01-2015. The subjects who met the inclusive criteria were selected by using convenient sampling technique. The researcher explained about the purpose and benefits of the study to the samples. The researcher assured of confidentiality and anonymity.

The demographic variables were collected by using the questionnaire. The questionnaire to assess the pretest knowledge and knowledge on practice regarding life style modification were distributed to fill in by the subjects. After collecting back

the questionnaire, teaching session was given for 45 minutes by using power point presentation and pamphlet were distributed to the patients. After 7 days, the post test was conducted to assess the knowledge and knowledge on practice regarding life style modification by using the same questionnaire.

Plan for Data Analysis

The investigator adopted the descriptive and inferential statistics to analyze the data. The demographic variables were analyzed by using frequency distribution and percentage. Comparison of the pretest and post test scores were computed on the basis of paired ‘t’ test.. Association of knowledge and knowledge on practice with selected demographic variables was computed based on chi-square test.

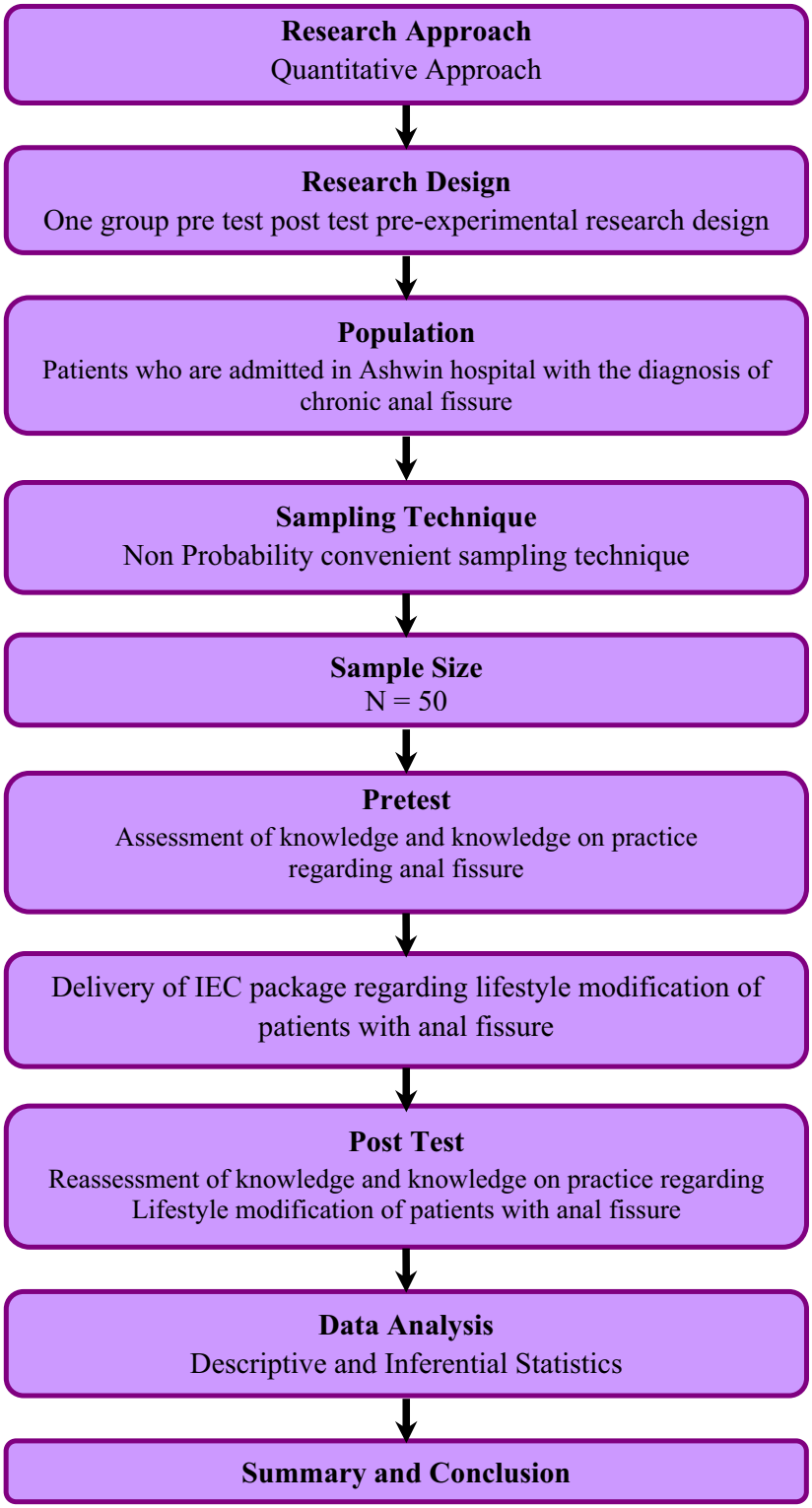

Figure. 3 The Overall View of Research Methodology

CHAPTER – IV

Data Analysis and Interpretation

This chapter deals with analysis and interpretation of the data collected from the patients with anal fissure, to assess the effectiveness of Information, education and communication package on knowledge and knowledge on practice. The findings based on the descriptive and inferential statistical analysis were presented under the following.

Section - I : Distribution of demographic variables of patient with anal fissure.

Section - II : Distribution of statistical value of pretest and post test knowledge mean score of patient with anal fissure.

Section - III : Distribution of statistical value of pretest and post test knowledge on practice mean score of patient with anal fissure.

Section - IV : Association of selected demographic variables with pretest knowledge score of patient with anal fissure.

Section - V : Association of selected demographic variables with pretest knowledge on practice score of patient with anal fissure.

SECTION - I

Table. 1 Distribution of Demographic Variables of Patient with Anal Fissure

(N = 50)

S. No.	Demographic Variables	Frequency (f)	Percentage %
1.	**Age (In Years)**		
	a) 21-30 years	6	12%
	b) 31-40 years	15	30%
	c) 41-50 years	12	24%
	d) 51-60 years	10	20%
	e) 60 and above	7	14%
2.	**Gender**		
	a) Male	22	44%
	b) Female	28	56%
3.	**Educational status**		
	a) Illiterate	2	4%
	b) Primary education	27	54%
	c) Secondary education	17	34%
	d) Graduate	4	8%
4.	**Occupational status**		
	a) Unemployed	5	10%
	b) Government Employee	12	24%
	c) Private employee	24	48%
	d) Self employed	9	18%
5.	**Economic Status**		
	a) Below ₹. 5000	3	6%
	b) ₹. 5001-10000	13	26%
	c) ₹. 10001-20000	17	34%
	d) ₹. 20001- 30000	10	20%
	e) ₹. 30001 and above	7	14%
6.	**Type of family**		
	a) Nuclear	14	28%
	b) Joint	16	32%
	c) Extended	20	40%

(Table 1 continues)

(Table 1 continued)

S. No.	Demographic Variables	Frequency (f)	Percentage %
7.	**Marital Status**		
	a) Married	30	60%
	b) Un married	19	38%
	c) Divorced	1	2%
	d) Widow/widower	0	0%
8.	**Religion**		
	a) Hindu	35	70%
	b) Muslim	10	20%
	c) Christian	5	10%
9.	**Type of Diet**		
	a) Mixed	21	42%
	b) Non- vegetarian	26	52%
	c) Vegetarian	3	6%
10.	**Social Habits**		
	a) None	28	56%
	b) Alcohol	10	20%
	c) Tobacco	7	14%
	d) Smoking	5	10%
11.	**Exercise**		
	a) Regular	25	50%
	b) Irregular	15	30%
	c) Rarely Performing	5	10%
	d) Not performing	5	10%
12.	**Previous information regarding anal fissure**		
	a) Radio and television	12	24%
	b) Newspaper and magazines	16	32%
	c) Health care personal	13	26%
	d) Own experience	9	18%
13.	**Any Family history of anal fissure**		
	a) No	39	78%
	b) Yes	11	22%

Table 1 reveals distribution of demographic variables of patient with anal fissure

Age distribution showed that 6(12%) of anal fissure clients were within 21-30 years of age, 15(30%) of them were in the age group of 31-40 years, 12(24%)between 41-50, 10(20%) of them in the age group of 51-60 years and 7(14%) were under 51-60 years of age.

The majority 28(56%) of the clients were females, about 22(44%) of clients were males.

Distribution of samples according to educational status revealed that 2(4%) were illiterate, 27(54%) were have primary education, 17(34%) were have secondary education and 04(8%) were Graduates.

Occupational status showed that 5(10%) of clients were unemployed, 12(24%) were Government employees, 24(48%) were private employees and 9(18%) were self employed.

It is observed that 3(6%) of the client's family income were less than ₹. 5000, a significant number 13(26%) of the clients had an income within ₹. 5001-10,000, 17(34%) of the clients had an income within ₹. 10,001-20,000 and 4(8%) are above ₹. 20001-30,000.

With regard to the type of family, majority 14(28%) of the clients lived in nuclear families, 16(32%) were belongs to joint family and a least 21(42%) lived in extended families.

Findings revealed that most 30(60%) of patients were married, 19(38%) were unmarried, 1(2%) were divorced and no widow/widower.

About religion majority 35(70%) were Hindus, 10(20%) were Muslims and 5(10%) Christians.

Regarding the type of diet 3(6%) were vegetarian, 26(52%) of clients having non-vegetarian diet and 21(44%) of the clients having mixed diet.

It is observed that about 28(56%) of the clients had no history of bad habits, 10(20%) of the clients had history of alcoholism, 7(14%) had tobacco chewing habit and 5(10%) having smoking habits.

The result showed that 25(50%) of the client performing regular exercise, 15(30%) were irregularly performing exercise, 5(10%) of clients were performing exercise rarely and 5(10%) were not have history of regular exercise.

Study showed that about 12(24%) of clients had got information from Radio and TV, 16(32%) of patients got information from newspaper and magazines, 13(26%) had got information from health care personals and 9(18%) of clients had own experience about the information regarding anal fissure.

Majority 39(78%) of the clients did not had any family history of anal fissure and 11(22%) of the clients had family history of anal fissure.

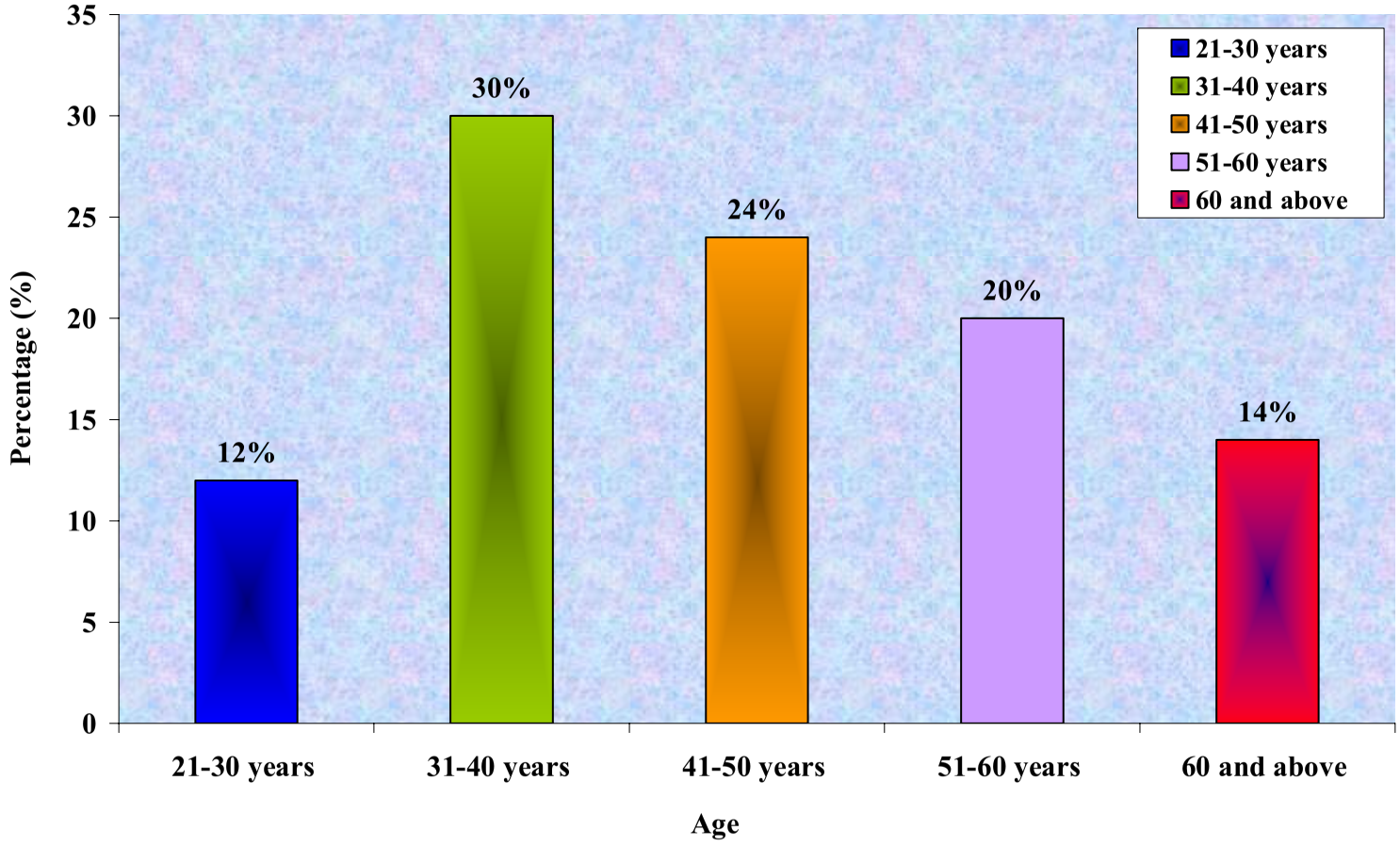

Figure. 4 Distribution of Demographic Variables According to the Age of the Patients

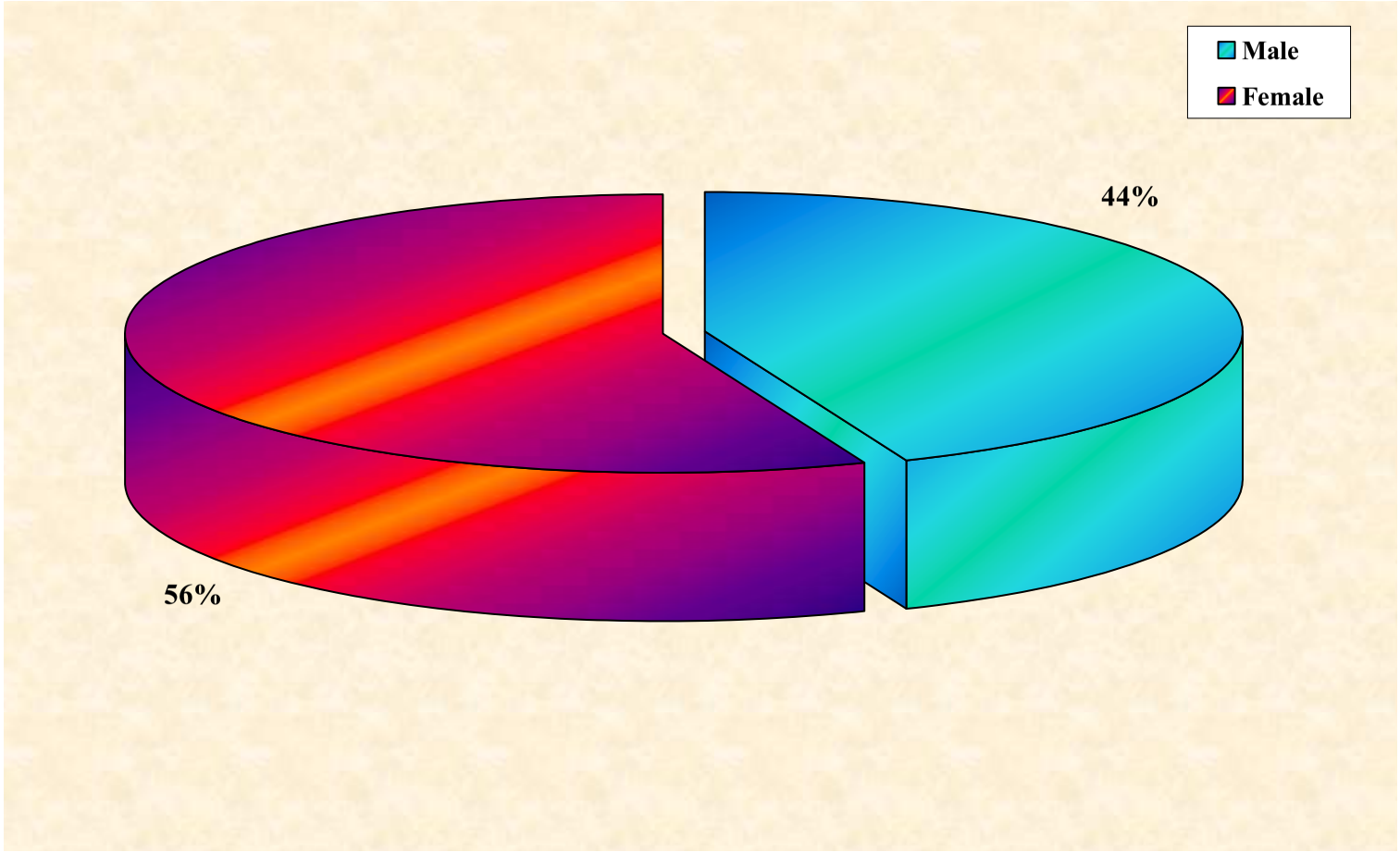

Figure. 5 Distribution of Demographic Variables According to the Gender of the Patients

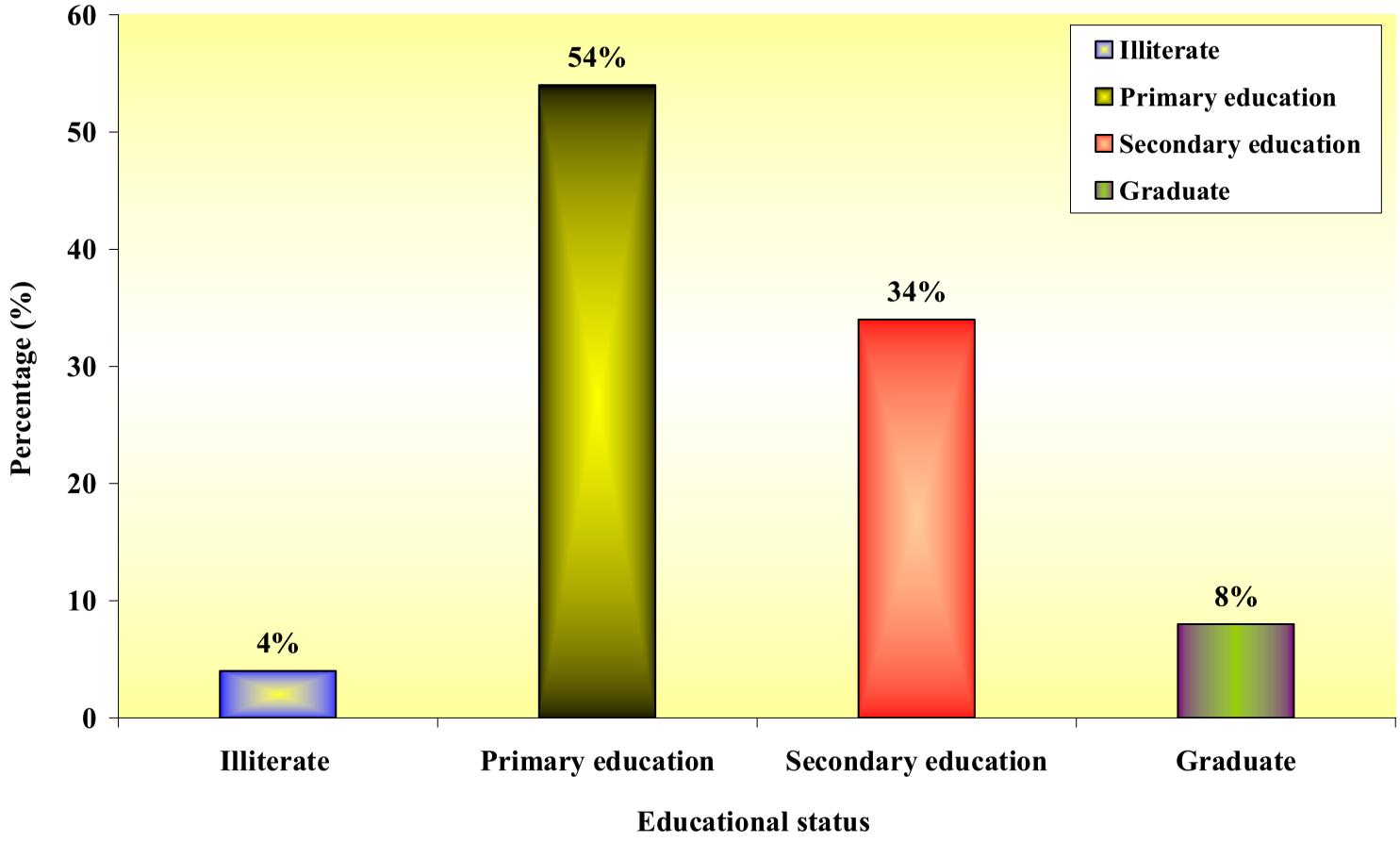

Figure. 6 Distribution of Demographic Variables According to the Educational Status of the Patients

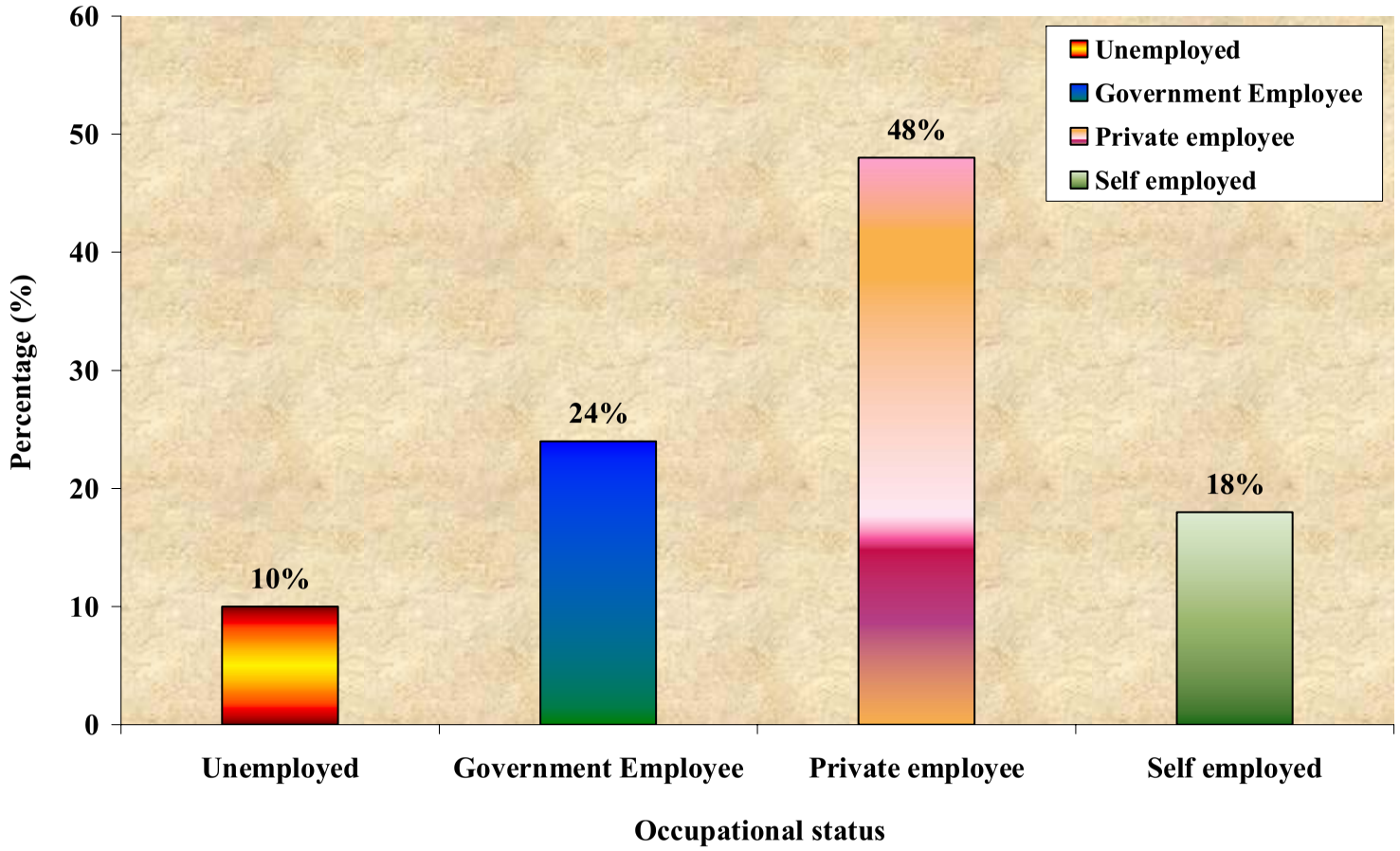

Figure. 7 Distribution of Demographic Variables According to the Occupational Status of the Patients

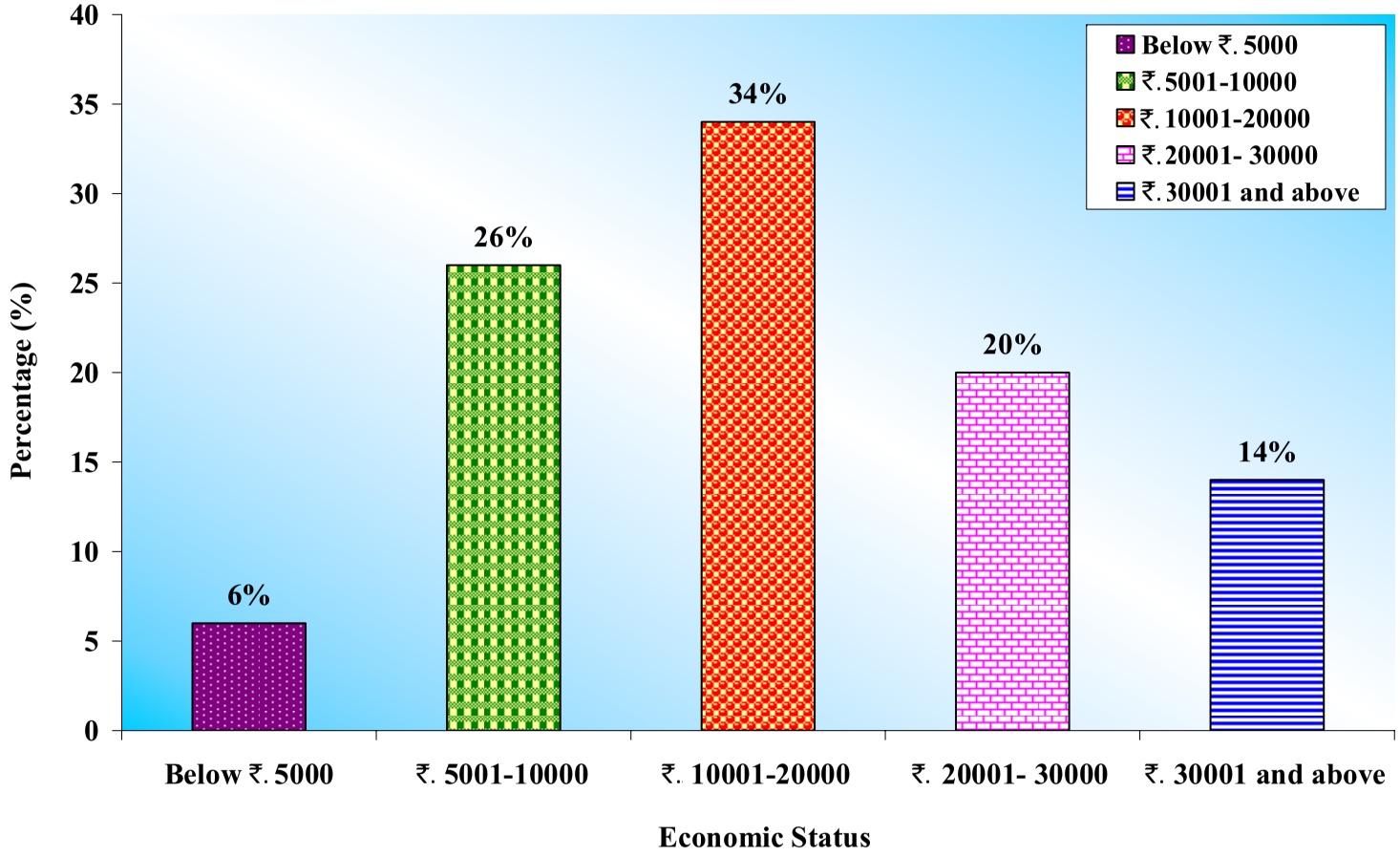

Figure. 8 Distribution of Demographic Variables According to the Monthly Income of the Patients

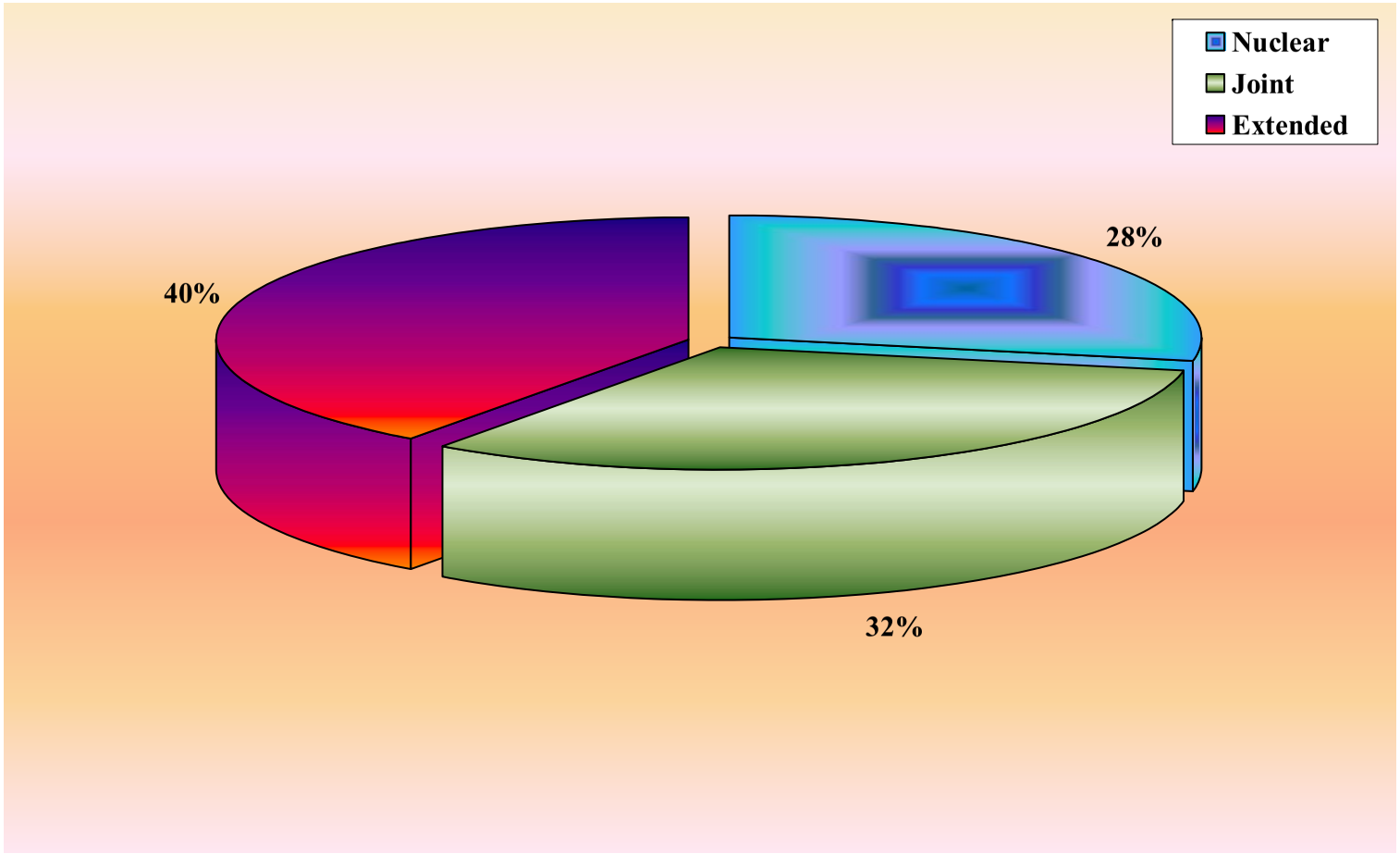

Figure. 9 Distribution of Demographic Variables According to the Type of Family of the Patients

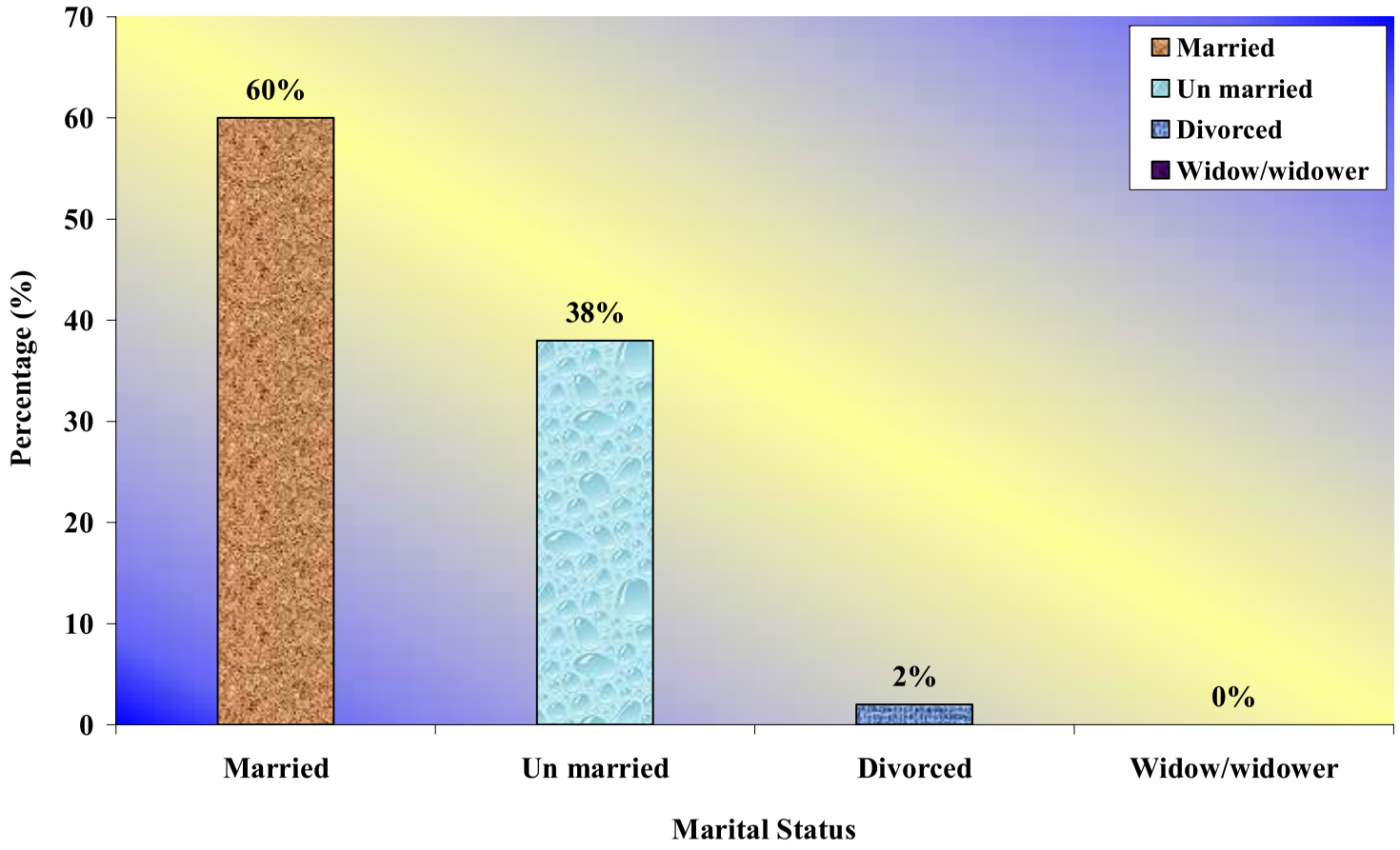

Figure. 10 Distribution of Demographic Variables According to the Marital Status of the Patients

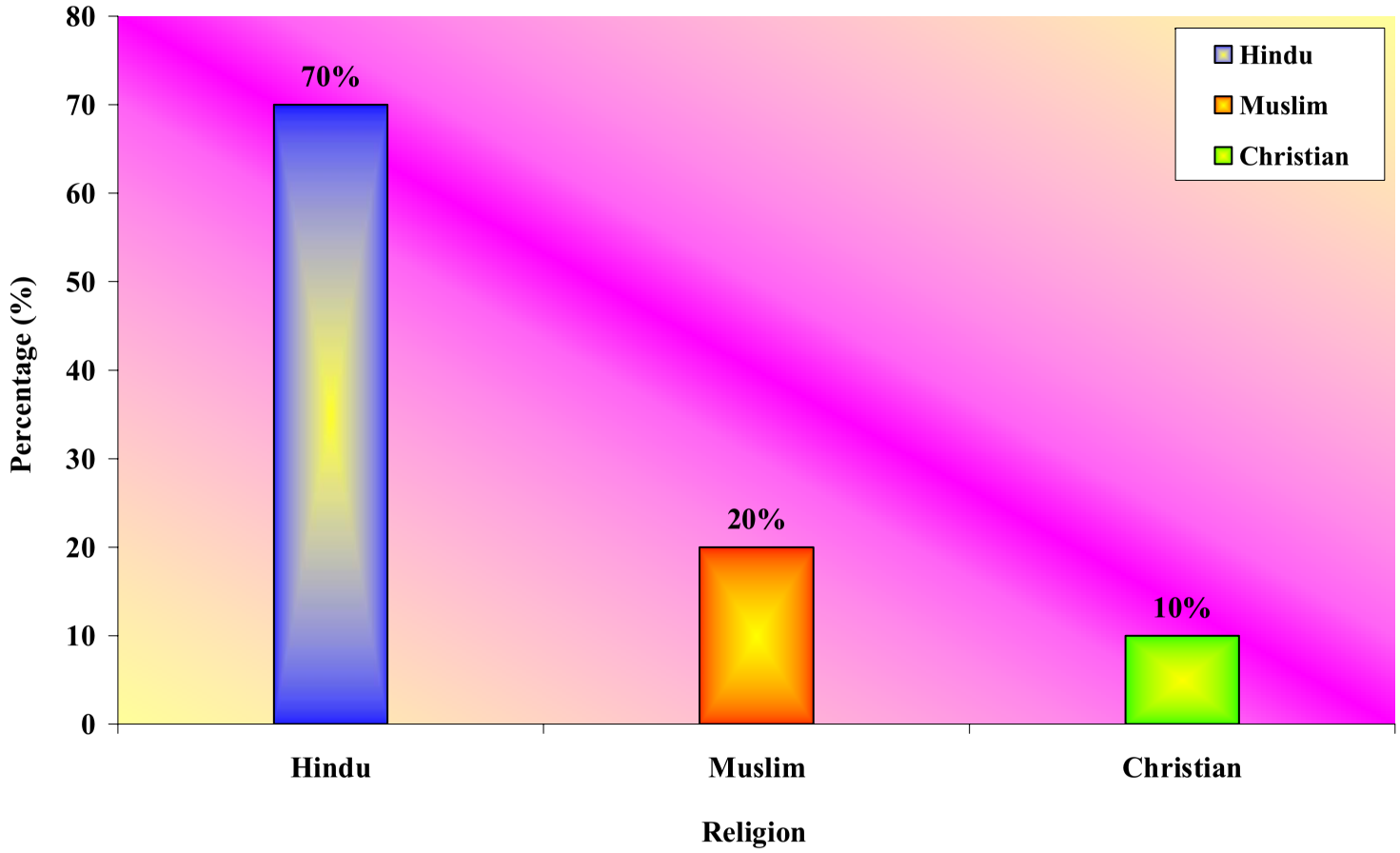

Figure. 11 Distribution of Demographic Variables According to the Religion of the Patients

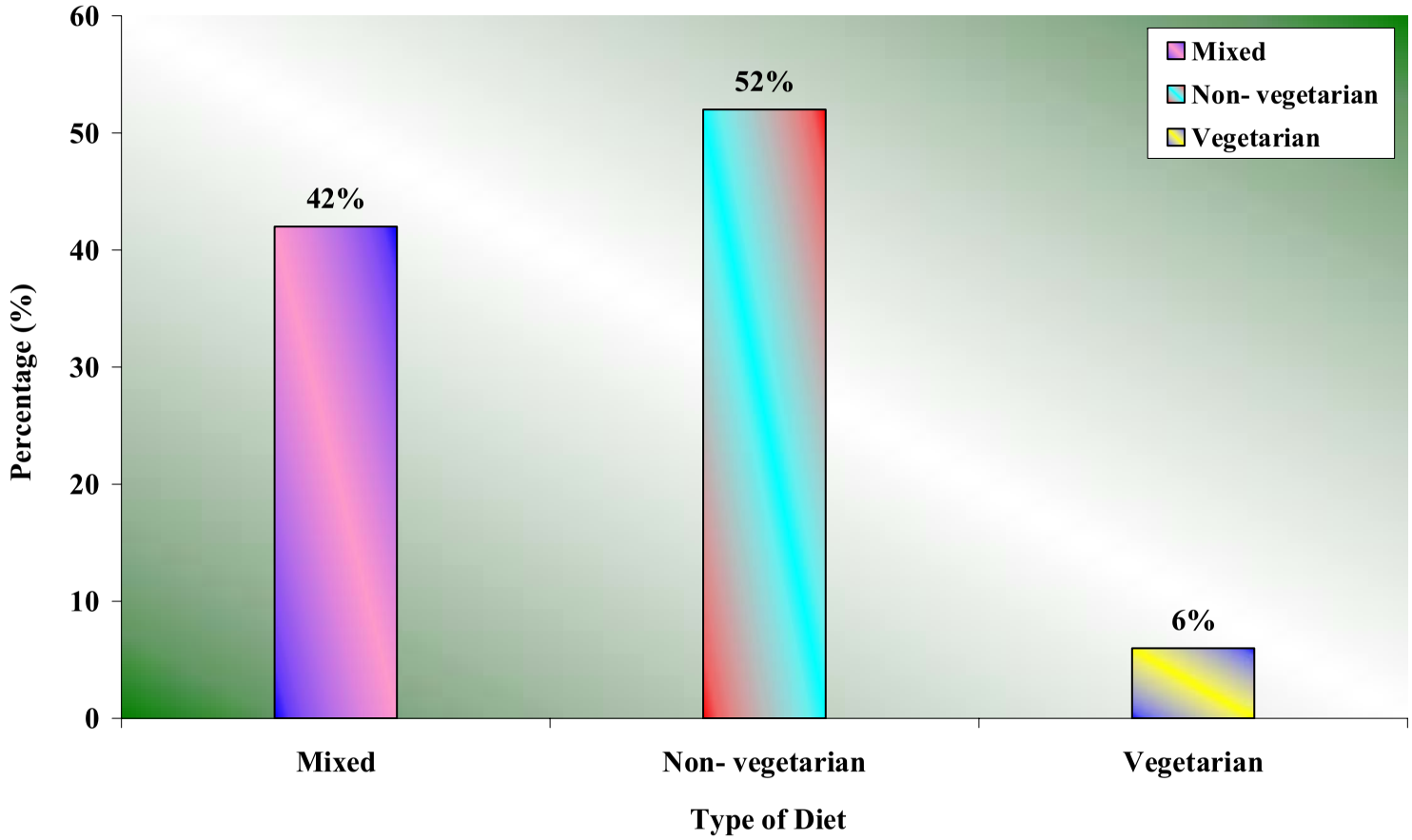

Figure. 12 Distribution of Demographic Variables According to the Dietary Pattern of the Patients

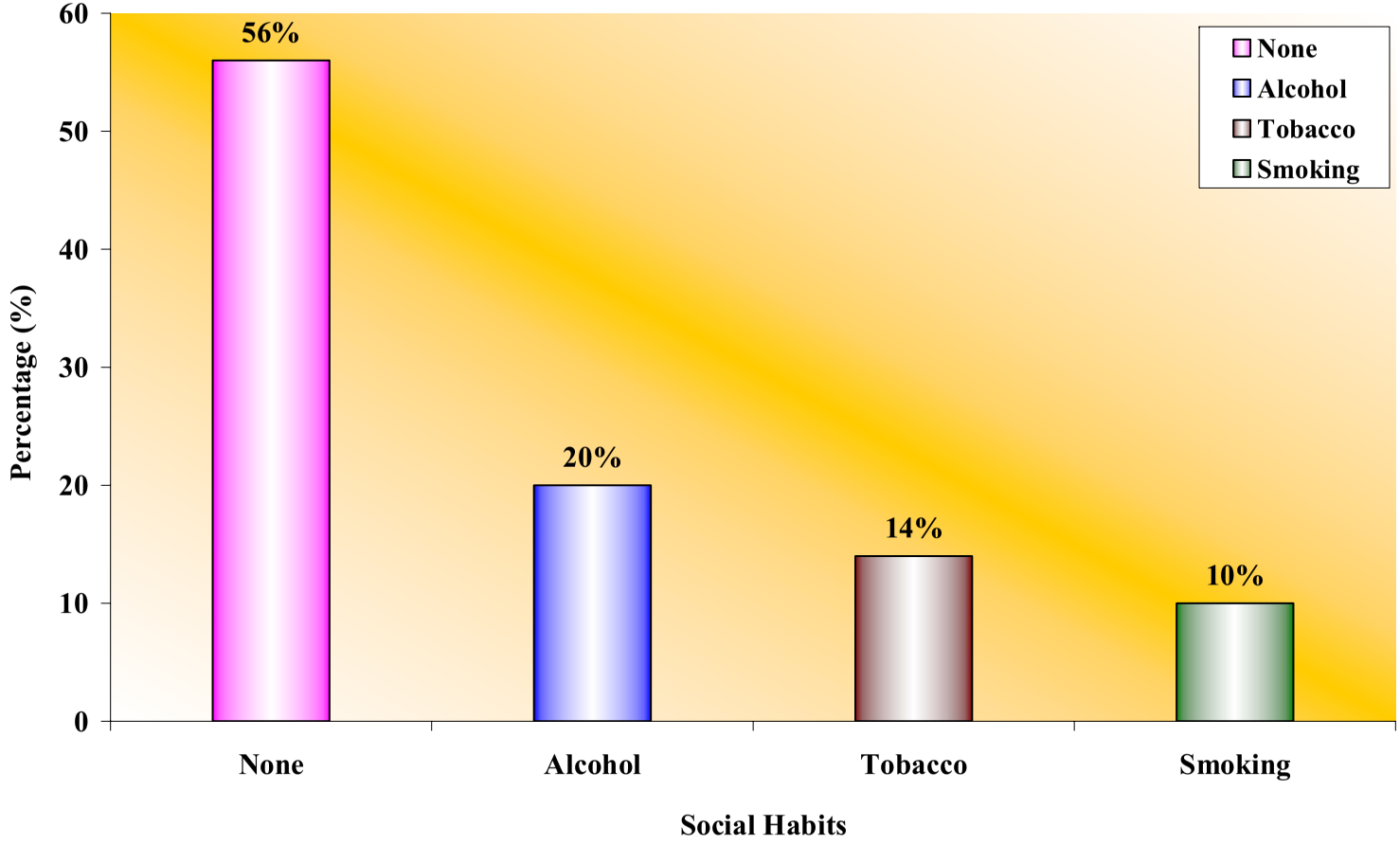

Figure. 13 Distribution of Demographic Variables According to the Social Habits of the Patients

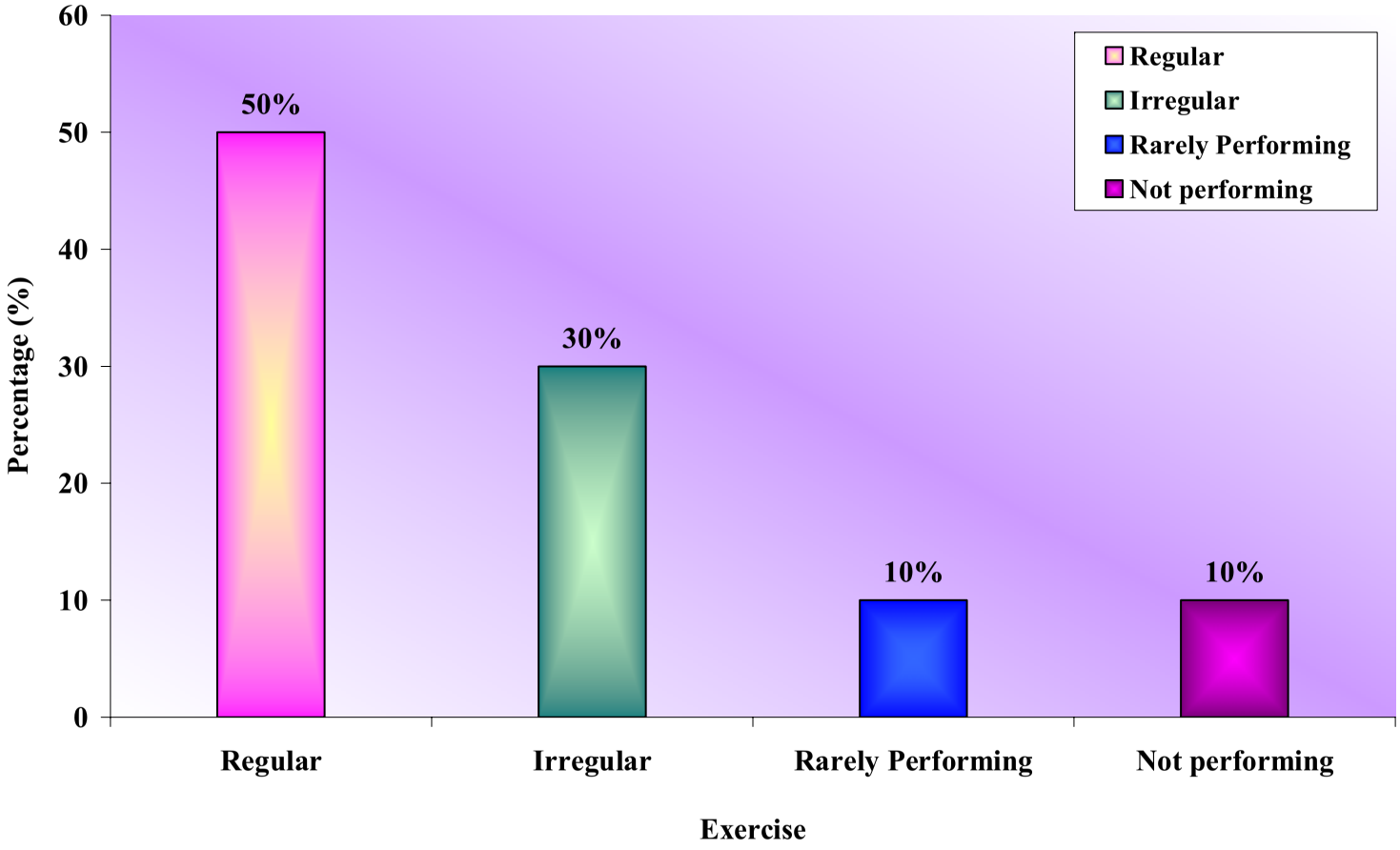

Figure. 14 Distribution of Demographic Variables According to the Exercise of the Patients

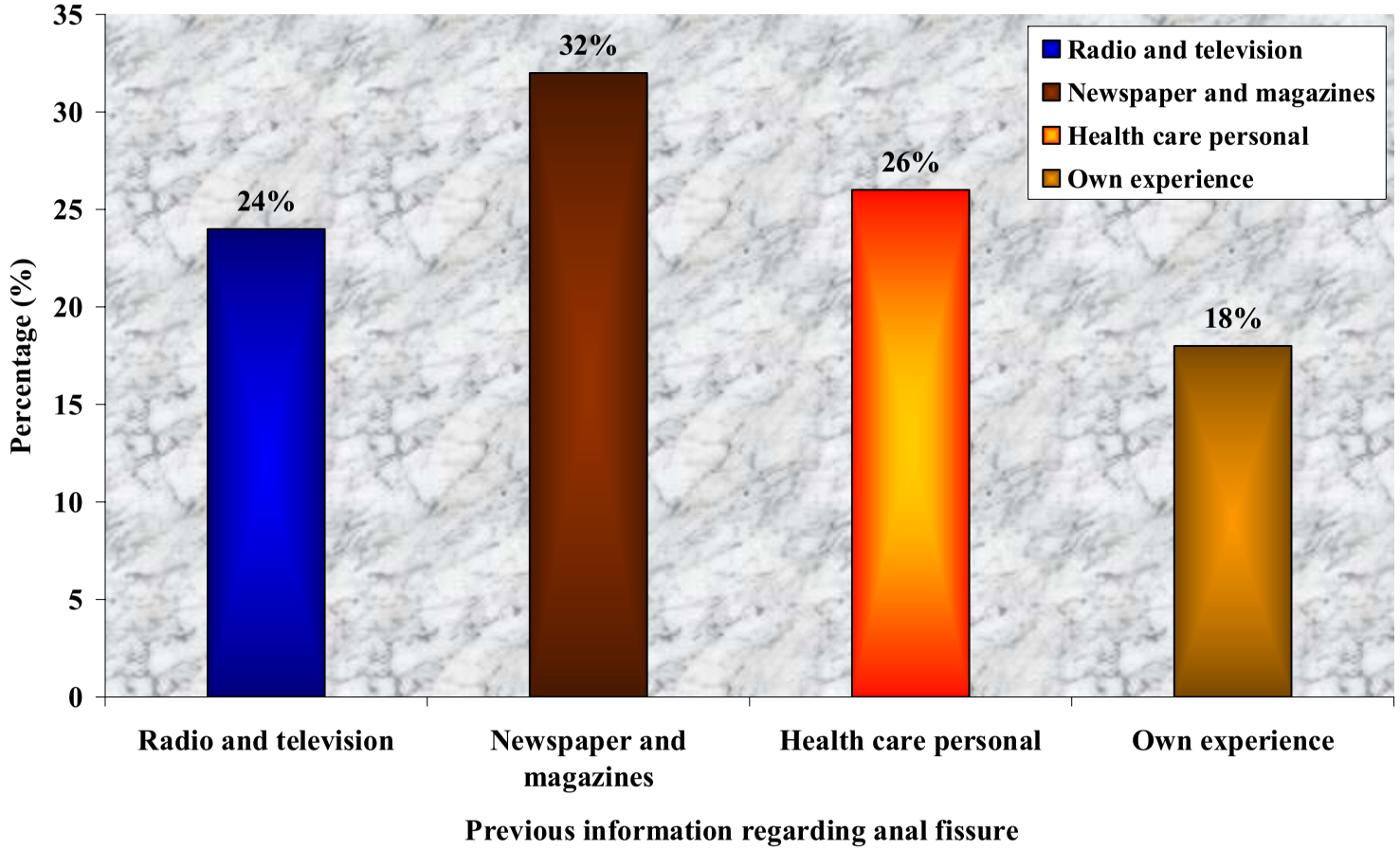

Figure. 15 Distribution of Demographic Variables According to the Source of Information of the Patients

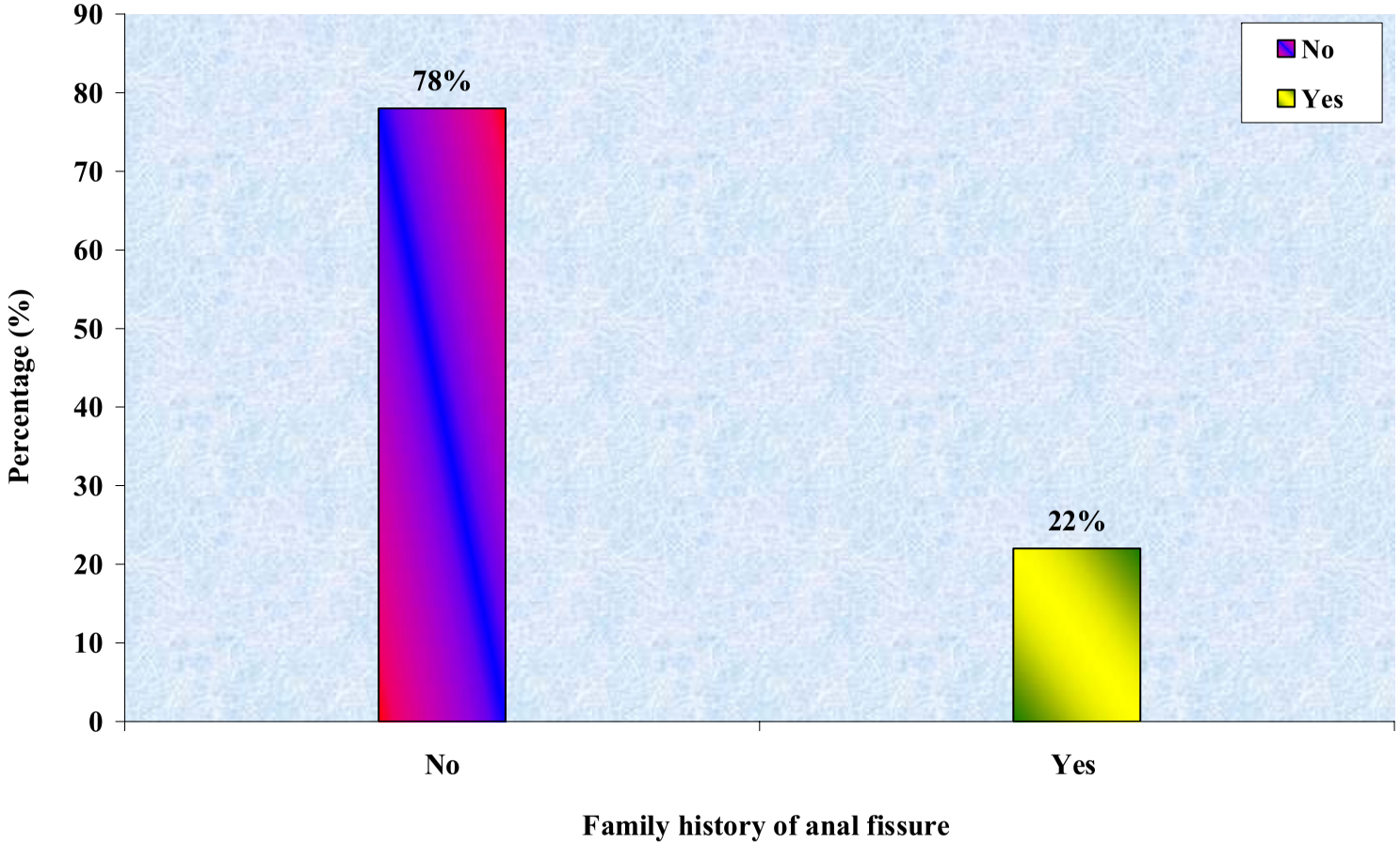

Figure. 16 Distribution of Demographic Variables According to the Family History of Patients with Anal Fissure

SECTION - II

Table. 2 Distribution of Statistical Value of Pretest and Post Test Knowledge Mean Score of Patient with Anal Fissure

(N = 50)

S. No.	Knowledge	Mean	S.D	't' Value	Level of Significance
1.	Pretest	14.5	3.76	15.58*	0.05
2.	Post test	20	1.4		

*significant

Table 2 shows that the pre test mean score was 14.5 and post test mean score was 20. The calculated 't' value 15.5 at df (49) is significant at 0.05 level. The finding implies that the Information, Education and communication package has significant effect in the improvement of knowledge regarding life style modification of anal fissure patients.

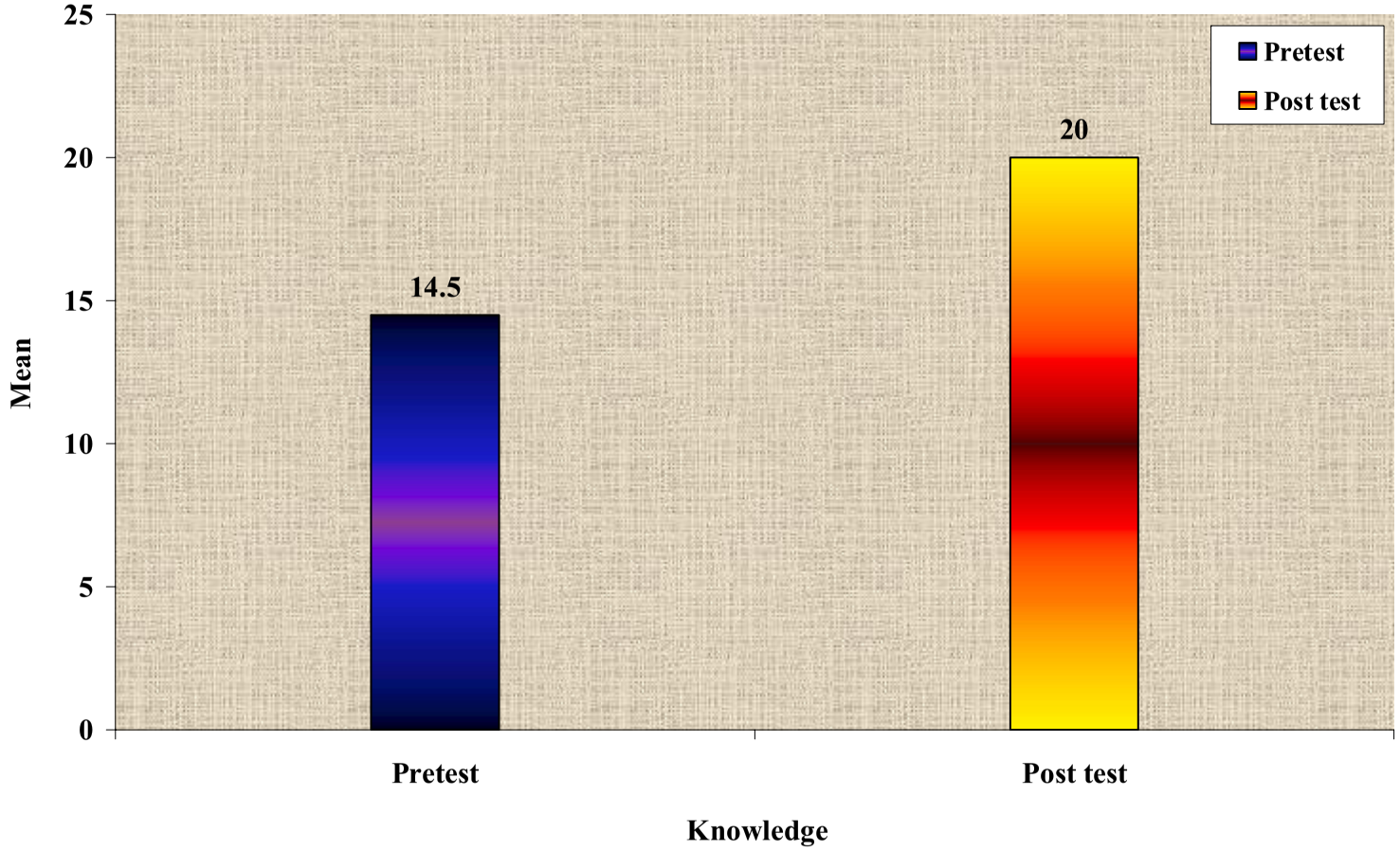

Figure. 17 Comparison of Pretest and Post Test Knowledge Score Regarding Lifestyle Modification of Patient with Anal Fissure

SECTION - III

Table. 3 Distribution of Statistical Value of Pretest and Post Test Knowledge on Practice Mean Score of Patient with Anal Fissure

(N = 50)

S. No.	Knowledge on Practice	Mean	S.D	't' Value	Level of Significance
1.	Pretest	10.7	2.4	16.0*	0.05
2.	Post test	13	1.5		

*Significant

Table 3 shows that the pre test mean score was 10.7 and post test mean score was 13. The calculated 't' value 16 at df(49) is significant at 0.05 level. The finding implies that the Information, Education and communication programme has significant effect in the improvement of knowledge on practice regarding life style modification of anal fissure patient.

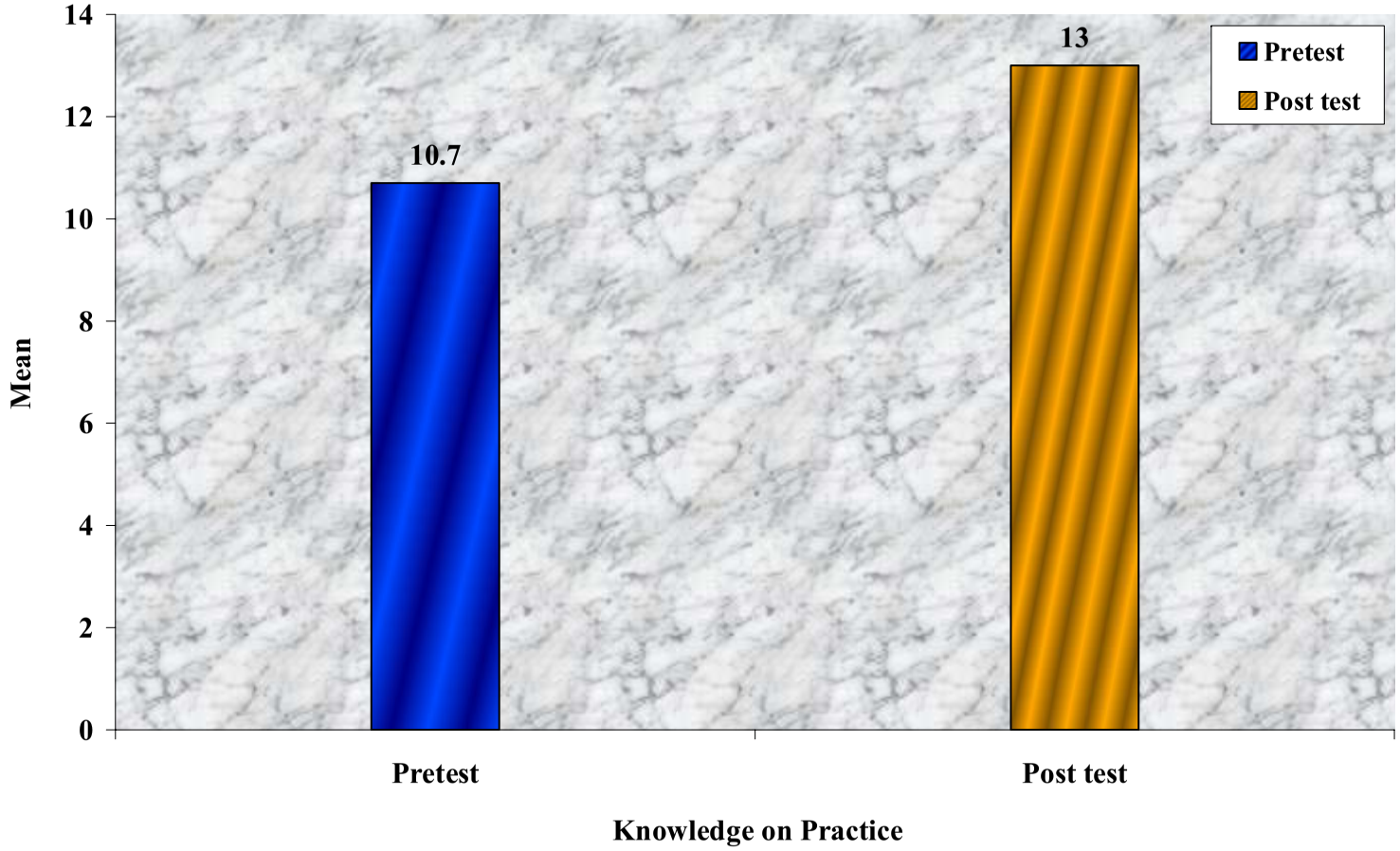

Figure. 18 Comparison of Mean Post Test Knowledge on Practice Score Regarding Lifestyle Modification of Patient with Anal Fissure

SECTION - IV

Table. 4 Association of Selected Demographic Variables with Pretest Knowledge Score of Patient with Anal Fissure

(N = 50)

S. No.	Demographic Variables	Above Mean	Below Mean	df	χ^2
1.	**Age (In Years)**				
	a) 21-30 years	5	1		
	b) 31-40 years	5	10		
	c) 41-50 years	11	1	4	14.67*
	d) 51-60 years	9	1		
	e) 60 and above	5	2		
2.	**Gender**				
	a) Male	12	10	1	2.21
	b) Female	23	5		
3.	**Type of Diet**				
	a) Mixed	13	8		
	b) Non- vegetarian	21	5	2	3.98
	c) Vegetarian	1	2		
4.	**Habits**				
	a) None	21	7		
	b) Alcohol	7	3	3	2.47
	c) Tobacco	5	2		
	d) Smoking	2	3		

(Table 4 continues)

(Table 4 continued)

S. No.	Demographic Variables	Above Mean	Below Mean	df	χ^2
5.	**Exercise**				
	a) Regular	21	4		
	b) Irregular	10	5	3	8.57*
	c) Rarely Performing	1	4		
	d) Not performing	3	2		
6.	**Any Family history of anal fissure**				
	a) No	25	14	1	2.93
	b) Yes	10	1		

*Significant

Table 4 shows the association of demographic variables with pre test scores of knowledge regarding the life style modification of patients with anal fissure. The obtained χ^2 value of age of patients is (14.67), exercise pattern (8.57) were significant at 0.05 level. The other demographic variables were not associated with knowledge.

SECTION - V

Table. 5 Association of Selected Demographic Variables with Pretest Knowledge on Practice Score of Patient with Anal Fissure

(N = 50)

S. No.	Demographic Variables	Above Mean	Below Mean	df	χ^2
1.	**Age (in years)**				
	a) 21-30 years	4	2		
	b) 31-40 years	4	11		
	c) 41-50 years	10	2	4	10.93*
	d) 51-60 years	7	3		
	e) 60 and above	4	3		
2.	**Gender**				
	a) Male	14	8	1	0.5
	b) Female	15	13		
3.	**Type of Diet**				
	a) Mixed	9	12		
	b) Non- vegetarian	17	9	2	4.69
	c) Vegetarian	3	0		
4.	**Habits**				
	a) None	16	12		
	b) Alcohol	6	4		
	c) Tobacco	4	3	3	0.03
	d) Smoking	3	2		

(Table 5 continues)

(Table 5 continued)

S. No.	Demographic Variables	Above Mean	Below Mean	df	χ^2
5.	**Exercise**				
	a) Regular	16	9		
	b) Irregular	6	9	3	3.3
	c) Rarely Performing	3	2		
	d) Not performing	4	1		
6.	**Any Family history of anal fissure**				
	a) No	20	19	1	2.6
	b) Yes	9	2		

*Significant

Table 5 shows the association of demographic variables with pre test scores of knowledge on practice regarding the life style modification of patients with anal fissure. The obtained x^2 value of age of patients is (10.93) is significant at 0.05 level. The other demographic variables were not associated with knowledge.

CHAPTER - V

Results and Discussion

The aim of the study was to assess the effectiveness of information communication and education package on knowledge and knowledge on practice of lifestyle modification among anal fissure patients. In this study one group pretest post test experimental study design was adopted. The data were analyzed by using descriptive and inferential statistics. The result of the study was discussed according to the objectives.

The First Objective of the Study was to Assess the Knowledge and Knowledge on Practice on Lifestyle Modification Among the Patients with Anal Fissure

The pretest knowledge and knowledge on practice towards the lifestyle modification of patient with anal fissure were assessed by using the questionnaire. The mean pretest of knowledge was 14.5 and post test was 20. The mean pretest of knowledge on practice was 10.7 and post test was 13. The mean difference implies that the subjects had inadequate knowledge and poor knowledge on practice towards the life style modification.

A study was conducted by A. K. Mourin (2011) to assess the knowledge and practice of anal fissure clients towards lifestyle modification. Data was collected using questionnaire and physical examination. The result shows that the awareness of anal fissure clients towards lifestyle modification was low and some patients had incorrect practice towards the management of anal fissure.

The Second Objective of the Study was to Deliver Information, Education and Communication Package Among Patients with Anal Fissure Regarding Life Style Modification

The information, communication and education package regarding the lifestyle modification on anal fissure was delivered to the patients with the help of power point presentation for 30 minutes and pamphlets were distributed regarding the lifestyle modification on anal fissure. The package consists of various management measures for anal fissure. The patients communicated their ideas actively and clarified their doubts.

Michael, et.al., (2012) conducted a study to assess the effectiveness of a information, education communication programme on lifestyle modification of anal fissure patients. The result of the study showed that the patients knowledge level was improved significantly regarding the lifestyle modification on anal fissure.

The Third Objective of the Study was to Evaluate the Effectiveness of Information, Education and Communication Package on Knowledge and Practice Regarding Life Style Modification Among Anal Fissure Patients

The mean pretest score of knowledge was 14.5 and post test was 20. The mean pretest score of knowledge on practice was 10.7 and post test was 13. Paired ‘t’ test was performed to assess the effectiveness of the intervention. The calculated ‘t’ value of knowledge score was 15.58 and knowledge on practice score was 16.

Both the ‘t’ value obtained for knowledge score and knowledge on practice score were higher than the table value at $p<0.05$ level of significance. This reveals

that there was a significant improvement in knowledge and knowledge on practice regarding the lifestyle modification of patients with anal fissure. This in turn reveals that the information, communication and education package was effective.

Karl Person's (2013) con ducted a similar study to assess the impact of information, communication and education package intervention on lifestyle modification of anal fissure. The patient were provided with repeated health education session and information about anal fissure management. After the intervention, it was found that the knowledge and knowledge on practice of the patients regarding lifestyle modification among anal fissure was improved significantly.

The Fourth Objective of the Study was to Find Out Association Between Selected Demographic Variables with Knowledge and Knowledge on Practice Regarding Lifestyle Modification of Patients with Anal Fissure

The demographic characters namely the age, gender, dietary pattern, social habits exercise pattern and family history were associated with knowledge and knowledge on practice by using χ^2 test. The results shows that age and exercise pattern influence on the pretest knowledge on person with anal fissure and on knowledge on practice, age of the patient influence the pretest knowledge of patients with anal fissure. The other demographic variables were not associated with knowledge.

Dundra. L (2012) conducted a study regarding the knowledge and practice of anal fissure patients in developing countries. The study showed that knowledge and practice of patients towards lifestyle modification on anal fissure had no significant relationship with age, gender, family history and exercise.

CHAPTER - VI

Summary, Conclusion, Nursing Implementations, Limitations and Recommendations

Summary

The study was conducted to assess the effectiveness of Information Education and Communication package in terms of Knowledge and Knowledge on Practice regarding Lifestyle modification among Anal Fissure patients in Ashwin Hospital, Coimbatore.

The Following Objectives were Set for the Study

- To assess the knowledge and knowledge on practice of lifestyle modification among the patients with anal fissure.
- To deliver Information, Education and Communication package among patients with anal fissure regarding life style modification.
- To evaluate the effectiveness of Information, Education and Communication package on knowledge and knowledge on practice regarding life style modification among anal fissure patients.
- To find out association between selected demographic variables with knowledge and knowledge on practice regarding lifestyle modification of patients with anal fissure

Hypothesis

H_1 There is a significant difference in the pre test and post test Knowledge and knowledge on practice score of anal fissure clients related to lifestyle changes after the Information, Education and Communication package.

Major Findings of the Study were as Follows

- The pretest mean value of knowledge was 14.5.
- The post test mean value of knowledge was 20.
- The obtained 't' value for comparison of knowledge score at $p<0.05$ level was 15.58.
- The pretest mean value of knowledge on practice was 10.7.
- The post test mean value of knowledge on practice was 13.
- The obtained 't' value for comparison of knowledge on practice score at $p<0.05$ level was 16
- The demographic variables age and exercise pattern shows significant association with pretest knowledge score regarding lifestyle modification of patients with anal fissure. Gender, dietary pattern, social habits and family history shows no significant association with pretest knowledge score about lifestyle modification of patients with anal fissure.
- The demographic variables age shows significant association with pretest knowledge on practice score regarding lifestyle modification of patients with anal fissure. Gender, dietary pattern, social habits, exercise pattern and family history shows no significant association with pretest knowledge on practice score regarding lifestyle modification of patients with anal fissure.

Conclusion

Hence it can be concluded that IEC package for anal fissure clients is an effective tool that implicated change in their knowledge and knowledge on practice. There is need for conscious efforts towards improving the level of awareness through health education and promotion, not limited to the hospital but also within the general

population, as part of strategies to prevent, manage and control anorectal diseases. Regular inculcation of health education, making the patient aware regarding the disease and encouraging self care management during treatment will reduce health care burden and help achieve optimal control of the disease with minimal long term complications. So the formulated hypothesis was accepted.

Nursing Implications

The findings of the study had the following implications on nursing practice, nursing education, nursing administration and nursing research.

Nursing Education

- Conduct nursing short term courses on conservative management for anal fissure clients, diet and exercise for lifestyle modification.
- Arrange in service education for nurses working in clinical areas on fibre rich diet and exercises. Include diet and exercise teaching in nursing education by including it in nursing syllabus. Curriculum should be designed to educate the student nurses to educate diabetes patients on life style modification.
- Develop hand book for nurses on diet and exercise in order to modify the lifestyle of the anal fissure clients.

Nursing Practice

- Nurse as a member of the health team plays a vital role in the management of patients with anorectal diseases.
- The present study revealed that the anal fissure clients had poor knowledge about the LSM and hence it is the responsibility of the nurse to the patients

about the importance of a proper diet, adherence to the treatment regimen and the necessity of exercising.

- Creating awareness among the clients is another urgent need of the hour to prevent complications of the disease by adhering to the diet and drug regimen as well as following regular exercising as a lifelong commitment.

Nursing Administration

- The nursing administration should take part in making health policy and developing protocols, standing orders related to anorectal education.
- The nursing administrators should concentrate on the proper selection, placement and effective utilization of the nurses in all areas giving opportunities for creativeness, creating interest and enhance ability in educating anal fissure clients.

Nursing Research

- The findings and results of this research study will motivate other nursing students to take up similar studies in different settings which will serve as a guideline to educate and provide care to the anal fissure clients.
- There is a need to standardize a teaching material which can be used in all regions according to the geographical variations in order to impart effective, accurate and useful information for the benefit of the population easily affected with anal fissure.

Limitations

- The size of the sample was small to draw generalizations
- The study was limited to the anal fissure clients admitted in selected hospitals.
- There was no control group in this study.

Recommendations

- A similar study can be done on a larger sample for wider generalizations.
- The IEC package developed by the investigator was found to be effective in increasing the knowledge of anal fissure clients and can therefore be utilized by health educators in various settings.
- A regular teaching programme may be implemented in institutions to teach about the anal fissure and its lifestyle modifications.
- Patients who are newly diagnosed with anal fissure can be provided with the pamphlets and/or booklets to impart knowledge about LSM among anal fissure clients.
- A comparative study can be conducted between conservative treatment and application of 0.2% GNT ointment.

REFERENCES

Books

- Abdull, F.G. (1999) . *Better Patient Care through Nursing Research*. (7th edition) . New York. Mac Millian Publishing Company.
- Arelene, P .et.al. (1996) . *Medical surgical nursing. (1st edition)* . New York: Saunders Puiblishers.
- Basavanthappa, B.T. (2003). *Nursing Research*. (15st edition) . New Delhi: Jaypee Brothers Medical Publishers.
- Basavanthappa, B.T. (2007) . *Nursing Theories.* (1st edition) . New Delhi: Jaypee Brothers Medical Publishers.
- Basavanthappa, B.T. (2008) . *Medical Surgical Nursing*. (1st edition) . New Delhi: Jaypee Brothers Medical Publishers.
- Bere & Myres, L. (2002) . *Adult Health Nursing*. (3rd edition) . Philadelphia: Mosby Company.
- Black J. M & Jacobs, E. M (2007) . *Medical Surgical Nursing* (5th edition) . Philadelphia: W. B. Saunders Company.
- Braun, W et al (2001) . *Harrison's Principles of Internal Medicine*. (12th edition) . New York: Mc Graw Hill Publishers.
- Braver, S. (2006) . The *measurement of clinical pain intensity*: A comparison of six methods. Pain (1st edition) . Bombay: Indian Printing House.
- Brunner & Suddarth (2007.*)* *Medical Surgical Nursing*. (11th edition) . Philadelphia: J.B Lippincott Company.
- Burns, N & Grove, S.K (2006) . *Understanding Nursing Research*. (2nd edition) . Philadelphia: W. B Saunders Company.

- Das S. A concise text book of surgery, 4th edition, Dr. S. Das Publications, Old Mayor's Court Calcutta, Page.no.1084-1086, Vol-13.(2011)
- Davidson, (2002) . Principals and Practice of Nursing. (19th edition) . New York: Churchill Livingstone Publishers.
- Dorothy, Y et.al (2003) . *Fundamentals of Nursing Research*. (3rd edition) . Canada: Jones Publishers.
- Gupta, S.P. (2006*)* . *Statistical Method.* (5th Edition) . New Delhi: Sultan Chand and Sons Education Publishers.
- Helen, J.S & Dona R (2006) . *Qualitative Research in Nursing*. (4th edition) . New York: Lippincott Williams and Wilkins.
- Ignastsvicius, D.D. & Linda, W. (2004) . *Text Book of Medical Surgical Nursing*. (4th Edition) . Philadelphia W.B Saunders Company.
- Kothari, C.R. (2007) . *Research Methodology and Techniques.* (3rd Edition) . New Delhi: International (P) Ltd.
- Lewis, S.M et.al (2006) . *Medical Surgical Nursing.* (7th edition) . London Mosby Publications.
- Luckmann, J (2008) . *Manuel of Nursing Care.* (1st Edition) . Philadelphia: LWW Publications.
- Mahajan, B.K (2007) . *Methods in Bio Statistics* (6th edition) . New Delhi: Jaypee Brothers Publications.
- Martha et al (2003) . *Nursing theory utilization and application*. (2nd edition) . Chicago: Lippincott publishers.
- Merlin, E.P (2007) . *Nursing Theory and Nursing Practice*. (1st edition) . New Delhi: Jaypee Publication.

- Pillai & Bagavathi. (2003) *Practical Statistics*. (1st edition) . New Delhi: S Chand and Sons Company.
- Polit & Beck (2004) . *Nursing Research Principles and Methods*. (7th edition) Philadelphia: Lippincott Company.
- Polit, D. F. & Hungler, B. P. (2004) . *Nursing Research Principles and Methods*. (7th Edition) . Philadelphia: Lippincott Company.
- Potter, P & Perry, A.G (2006) . *Fundamentals of Nursing*. (5th edition) . St. Louis: Lippincott Publications.
- Shafers. (2004) . *Medical Surgical Nursing*. (7th edition) . New Delhi: B.I. Publication.
- Watson. (1992) . *Medical Surgical Nursing*. (4th edition) . Philadelphia: Elbs Tin Doel Publications.
- White, L. (2011) . *Foundations of Nursing*. (1st edition) . New York: Delmer Thomson Publisher.

Journals

- Ali Fakhr Movahedi, (2011) . Anal fissure a comprehensive method. *Australian journal of advanced nursing*, 24 (2) , 51-53.
- Amy. E. Lacroxi, (2012) . Beneficial effect dietary pattern for anal fissure. *England journal of nursing*, 24(6) , 445-453.
- Amarjeet Singh. (2011) . Do We Really Need to Pedestal Type of Latrines in India? Indian Journal of Community Medicine.
- Aziz A, (2011) . Sheikh I. Lateral subcutaneous internal sphincterotomy in chronic anal fissure. Pakisthan Journal of Surgery. 45 – 21-26.
- Baxter and Andrew Moore (2009) . Minimizing Pain on anal fissure. *British Journals*. Vol-17, 885.

- Clarke, D.B. & Barnes, A.D. (2000) . Intensive care for patients -JACOH. Journal of associations of physicians in India. 23(6) , 885-891.
- Dealtry, R. (2005) . The challenge of acute pain management. *Asian Journal of Cardiovascular Nursing.* 3(2) , 34-37.
- Donna, S.C & Gayle, N. (2003) . Clinical study: the value of therapeutic touch on anal fissure. *Holistic Nursing Practice*. 17(4) , 189-192.
- Dr. Tariq Wahab Khanzada (2013) . Chronic Anal fissures; Topical Glyceryl trinitrate versus lateral internal sphincterotomy – International Journal of Colorectal Disease. Professional Med J; 14 (2) ; 318 – 322.
- Gold J.I (2006) . Complimentary therapies- effective of fissure. *Indian Journal of Holistic Nursing*. 4(4) , 8-10.
- Hadley, S., Chang, M., & Rogers, K. (2009) . Effect of sitz bath on bruising pain of anal fissure. *American Journal of Critical Care*, 5, 271-276.
- M D. Ibrahim Siddique, Khandker Manzoor Murshed (2011) . Comparative Study of lateral internal sphincterotomy versus local 0.2% Glyceryl trinitrate ointment for the treatment of chronic anal fissure – International Journal of Colorectal Disease, Bangladesh Med Res Counc Bull ; 34 ; 12 – 15.
- P. Gupta, Internal anal sphincterolysis for chronic anal fissure ; the American Journal of Surgery, 2012 Volume 253, Issue 1, page 13-16.
- Shao W J, Zhang ZK.(2011) . Systematic review and meta-analysis of randomized controlled trials comparing botulinum toxin injection with lateral internal sphincterotomy for chronic anal fissure. International Journal of Colorectal Disease. 14(5) , 18-21**.**
- Sherly (2010) . Assessing pain: vital part of nursing care. *Nightingale Nursing Times.* 14(2) , 298-305.

- Singer A.J (2008) . Lifestyle modification for fissure free pain. *Journal society of nurses.* Vol 24 (2) :29-33.

Online Abstracts

- Acheson AG, Schole field JH. (2015) . Anal fissure: the changing management of a surgical condition. *http://www.ncbi.nlm.nih.gov/pubmed.*
- Antonio Arroyo, Francisco Pérez, Pilar Serrano, Fernando Candela (2013) . Surgical versus chemical (botulinum toxin) sphincterotomy for chronic anal fissure: longterm results of a prospective randomized clinical and manometric study. Available *from URL: http://www.ncbi.nlm.nih.gov/pubmed.*
- Ayantunde A, Debrah S A (2015) . Current concepts in anal fissures. *http://www.ncbi.nlm.nih.gov/pubmed.*
- Bhardwaj R, Parker MC. Modern (2015) . Perspectives in the treatment of chronic anal fissures. *http://www.ncbi.nlm.nih.gov/pubmed.*
- Carapeti EA, KammMA, Philips RK (2011) . Topical diltiazem and bethanechol decrease anal sphincter pressure and heal anal fissures without side effects. Available from *URL: http://www.ncbi.nlm.nih.gov/pubmed.*
- Danakas G. Anal fissure. Instant Diagnosis and Treatment.1st ed. Ferri's Clinical Advisor Philadelphia Available from *http://www.nlm.nih.gov/medlineplus.html.*
- Dunning T, James K, (2001) . Complementary therapies in action-education and outcomes. Retrieved from *NCBI website.*
- García-Granero E, Muñoz-Forner E, Mínguez M, Ballester C, García-Botello S, Lledó S (2015) .. Treatment of chronic anal fissure. *http://www.ncbi.nlm.nih.gov /pubmed.*

- Garg P, Garg M, Menon GR (2013) . Long term continence disturbance after lateral internal sphincterotomy for chronic anal fissure: A systematic review and metaanalysis. Colorectal Disease. *Pubmedhealth.com*
- Gomet .M .D; Peter H(2008) . "New Therapy Coming for Anal Fissures". Available from *URL: http://en.wikipedia.org/wiki/Anal_fissure*
- Isbister W H, Prasad J. Fissure-in-Ano (2012) . Available from URL *http://www.ncbi.nlm.nih.gov/pmc/articles* .
- Jensen S L.(2012) . Maintenance therapy with unprocessed bran in the prevention of acute anal fissure recurrence. Available from: *http://www.ncbi.nlm.nih.gov/ pmc/ articles.*
- Jensen S L.(2012) . Treatment of first episodes of acute anal fissure: prospective randomized study of lignocaine ointment versus hydrocortisone ointment or warm sitz baths plus bran. Available from *URL: http://www.ncbi.nlm.nih.gov/pubmed.*
- John L, Pfenninger, George G. Zainla.(2012) Common Anorectal Conditions: part 2 Lesions ; Available from *URL: http://www.aafp.org/afp*
- Jonas M, Scholefield JH.(2014) . Anal Fissure. Available from URL: *http://www.ncbi.nlm.nih.gov/pubmed.*
- Kiva K. Paul,(2010) . "Total health tips on Hemorrhoids". Available from *URL:http://totalhealthtips.org.*
- Lt Col S Mehrotra. (2009) . Beyond Beauty: Botulinum Toxin Use in Anal Fissure. *http://www.aafp.org/afp.*
- Mc Callion K, Gardiner KR. (2015) . Progress in the understanding and treatment of chronic anal fissure. *http://www.ncbi.nlm.nih.gov/pubmed*
- Minguez M, Herreros B, Benages A. (2015) . Chronic Anal Fissure. *http://www.ncbi.nlm.nih.gov/pubmed.*

- Michael A. Valente D O (2012) . Anal fissure. American society of colon and rectal surgeons. Public relation committee; Dec; P 01-08. Available from: *http://www.fascrs.org/patients/conditions/anal fissure/anal fissure.*
- Nelson R. (2015) . Non surgical therapy for anal fissure. *http://www.ncbi.nlm.nih.gov/pubmed.*
- Nelson RL. (2015). Anal fissure (chronic) . *http://www.ncbi.nlm.nih.gov/pubmed/.*
- Omer El Farouq El tinay, Salman Yousuf Guraya (2011) . Dept of Surgery. King Khalid University Hospital, Riyadh. Soudi Arabia. The use of 0.2% Glyceryl Trinitrate ointment for anal fissures *http://www.ncbi.nlm.nih.gov/pubmed.*
- P.A.Haas,G.P et al. (1983) .“The Prevalence of Hemmorrhoids”. Available from: *http://www.the doctor.com/diseases/hemorrhoids.html.*
- Perez-Miranda-M, Robledo P, Alcalde M, Gomez-Cedenilla. (2012) -A Mate-Jimenez J, Endoscopic anal dilatation for fissure in ano- a new outpatient treatment modality. Available from URL: *http://www.ncbi.nlm.nih.gov/pmc /articles.*
- Perry WB, Dykes SL, Buse WD, Ralferty (2012) . Standards practice task force of the American society of colon and surgeon practice parameters for the management of anal fissures. Available from URL: *http://www.ncbi.nlm. gov/pubmedhealth.*
- Rebecca Waller (2010) . GP using complementary and alternative therapies. Retrieved from *www.netdoctor.co.uk.*
- Rick Nelson (2015) . Anal fissure (chronic) . *http://www.ncbi.nlm.nih.gov/pmc /articles.*
- Sajid M S, Hunte S, Hippolyte S, Kiri VA, Maringe C, Baig MK (2013) . Comparison of surgical vs chemical sphincterotomy using botulinum toxin for the

treatment of chronic anal fissure: a meta-analysis. Colorectal Disease Available from: *URL: http://www.ncbi.nlm.nih.gov/pubmedhealth.*

- Sajid MS, Hunte S, Hippolyte S, Kiri VA, Maringe C, Baig M K (2014) . Systematic review and meta-analysis of randomized controlled trials comparing botulinum toxin injection with lateral internal sphincterotomy for chronic anal fissure. Colorectal Disease. *www.ncbi.nlm.nih.gov/pubmedhealth.*
- Sajid MS, Vijaynagar B, Desai M, Cheek E, Baig M K (2012) . Botulinum toxin vs glyceryltrinitrate for the medical management of chronic anal fissure: a metaanalysis. Colorectal Disease. *http://www.ncbi.nlm.nih.gov/pubmedhealth.*
- Samanesh Bagherian and Pan, C. et.al. (2011) . Complementary and Alternative Medicine in the management of Pain, Dyspnea and Nausea and Vomiting. Retrieved from *www.pubmed.com.*
- Sanju Dhawan, and Sunny Chopra. (2013) . Nonsurgical Approaches for the Treatment of Anal Fissures *http://www.nature.com/ajg/journal.*
- Utzig M J, Kroesen AJ, Buhr H J (2013) . Concept in pathogenesis and treatment of chronic anal fissure- a review of literature. Available from URL: *http://www.ncbi.nlm.nih.gov/pubmedhealth.*
- Vincenzo Berghella, Oliver Paut. (2013) . Patient information; C section. Retrieved from *www.update .com/contents/C- Section_intravenouscannulation.*
- WHO. (2010) . Pain. Retrieved from *www.health.com*
- Widmer M, Donges A, (2007) . The supply of complementary therapy in Swiss hospitals. Retrieved from *www.pubmed-indexed for medline.*

ABSTRACT

Statement of the Problem : A study to assess the effectiveness of Information Education and Communication package in terms of Knowledge and Knowledge on Practice regarding Lifestyle modification among Anal Fissure patients in Ashwin Hospital, Coimbatore. **Objectives: (a)** To assess the knowledge and knowledge on practice of lifestyle modification among the patients with anal fissure. **(b)** To deliver Information, Education and Communication package among patients with anal fissure regarding life style modification. **(c)** To evaluate the effectiveness of Information, Education and Communication package on knowledge and practice regarding life style modification among anal fissure patients. **(d)** To find out association between selected demographic variables with knowledge and knowledge on practice regarding lifestyle modification of patients with anal fissure. **Methodology :** One group pretest post test experimental design. The sample for this study consists of 50 samples of patients with anal fissure selected a convenient sampling method. A structured Questionnaire was used to assess the knowledge and knowledge on practice. **Results :** The mean post test score after the IEC package was higher than mean pretest score in knowledge practice. The post test knowledge score was 20. The obtained 't' value for the comparison of knowledge score was 15.58 at 49 (df) significant at ($P<0.05$) level. The post test knowledge on practice score was 13. The obtained 't' value for the comparison of knowledge on practice score was 16 at 49(df) significant at ($P<0.05$) level. The educational status has influence on the post test knowledge and knowledge on practice among patients with anal fissure. **Conclusion :** The life style modification has significant effect in management of anal fissure after the IEC package and pamphlet improve the knowledge and knowledge on practice of life style modification among patients with anal fissure.

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To

Through

The Principal,
PPG College of Nursing
Coimbatore – 35.

Respected Sir,

Sub : Seeking permission for conducting research study

I am a student of M.Sc Nursing in PPG College of Nursing. Our college is affiliated to the Tamilnadu Dr. M. G. R Medical University, Chennai. I have taken the specialization in Medical Surgical Nursing.

Topic : **A STUDY TO ASSESS THE EFFECTIVENESS OF INFORMATION EDUCATION AND COMMUNICATION PACKAGE IN TERMS OF KNOWLEDGE AND KNOWLEDGE ON PRACTICE REGARDING LIFESTYLE MODIFICATION AMONG ANAL FISSURE PATIENTS IN ASHWIN HOSPITAL, COIMBATORE.**

I request you to kindly permit me to conduct my study in hospital. Hope you will consider my requisition and do the needful.

Thanking you,

Yours sincerely,

Date :

Place : Coimbatore

Requisition Letter for Content Validity

From

M.Sc (N) II Year,
PPG College of Nursing,
Coimbatore – 35.

To

Through : Principal, PPG College of Nursing

Respected Sir/Madam,

Sub : Requisition for expert opinion and suggestion for content validity of tool

I am a student of M.Sc (N) II year, PPG College of Nursing affiliated to the Tamilnadu Dr. M. G. R. Medical University, Chennai. As a partial fulfillment of the M.Sc (N) programme. I am conducting

A STUDY TO ASSESS THE EFFECTIVENESS OF INFORMATION EDUCATION AND COMMUNICATION PACKAGE IN TERMS OF KNOWLEDGE AND KNOWLEDGE ON PRACTICE REGARDING LIFESTYLE MODIFICATION AMONG ANAL FISSURE PATIENTS IN ASHWIN HOSPITAL, COIMBATORE.

Herewith I have enclosed the developed tool for content validity and for the expert opinion and possible solution. It would be very kind of you to return the same as early as possible.

Thanking you,

Yours faithfully,

Format for the Content Validity

Name of the expert :

Address :

Total content for the tool :

Kindly validate each tool and tick wherever applicable

S.No	No. of Tool/Section	Strongly Agree	Agree	O.K	Not Applicable	Need Modification	Remarks

Remarks

Signature of the Expert with Date

LIST OF EXPERTS

1. **Dr. L.P THANGAVELU**

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2. **Dr. RAJPAL K ABAICHAND**

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SECTION - I

Demographic Variables

Instruction

Read the following questions carefully and given (✓) in a given boxes for correct answer.

Sample No: …….....

1. Age (in years)

a) 21- 30 years ☐

b) 31-40 years ☐

c) 41- 50 years ☐

d) 51-60 years ☐

e) 60 above ☐

2. Gender

a) Male ☐

b) Female ☐

3. Educational status

a) Illiterate ☐

b) Primary education ☐

c) Secondary education ☐

d) Graduate ☐

4. Occupational status

a) Unemployed ☐

b) Government employee ☐

c) private employee ☐

d) self employed ☐

e) Any other ☐

5. Economic status

a) Below ₹. 5000 ☐

b) ₹. 5001- 10,000 ☐

c) ₹. 10,001- 20,000 ☐

d) ₹. 20,001- 30,000 ☐

e) ₹. 30,000 & above ☐

6. Type of family

a) Nuclear ☐

b) Joint ☐

c) Extended ☐

7. Marital status

a) Married ☐

b) Unmarried ☐

c) Widow/Widower ☐

d) Divorced ☐

e) Separated ☐

8. Religion

a) Hindu ☐

b) Muslim ☐

c) Christian ☐

d) Any other ☐

9. Type of Diet

a) Vegetarian ☐

b) Non vegetarian ☐

c) Mixed ☐

10. Habits

a) Smoking ☐

b) Alcohol ☐

c) Tobacco chewing ☐

d) Other drugs ☐

e) None ☐

11. Exercise

a) Regularly performing ☐

b) Irregular ☐

c) Rarely performing ☐

d) Not performing ☐

12. Previous information regarding anal fissure

a) Radio and television ☐

b) News paper and magazines ☐

c) Health care personnel's ☐

d) Own experience ☐

13. Any family history of anal fissure

a) Yes ☐

b) No ☐

SECTION - II

Structured Knowledge Questionnaire

Instruction

Read the following questions carefully and tick (✓) the correct most appropriate answer.

1. Which of the following is a digestive organ?
    a) Kidney ☐
    b) Stomach ☐
    c) Heart ☐
    d) Lungs ☐

2. Which organs consists digestive system?
    a) Kidney, ureters and urinary bladder ☐
    b) Neurons, brain, and skull ☐
    c) Esophagus, stomach, and intestine ☐
    d) Ear, nose, throat ☐

3. What is the function of stomach?
    a) Storage and digestion of food ☐
    b) Release proteins ☐
    c) Excrete food ☐
    d) None of the above ☐

4. What is the length of small intestine?

    a) 2 meters ☐

    b) 3.5 meters ☐

    c) 6 meters ☐

    d) 4 meters ☐

5. Which of the following is accessory organ of digestive system?

    a) Heart ☐

    b) Kidney ☐

    c) Liver ☐

    d) Intestine ☐

6. What is the function of anus?

    a) Storage of feces ☐

    b) Expulsion of feces ☐

    c) Production of feces ☐

    d) Other ☐

7. Where food enters into the body?

    a) Tongue ☐

    b) Mouth ☐

    c) Pharynx ☐

    d) Esophagus ☐

8. Where digestive system completes digestion and absorption of food?

   a) Small intestine ☐
   b) Large intestine ☐
   c) Stomach ☐
   d) Pancreas ☐

9. What is anal fissure?

   a) Tear in anal canal ☐
   b) Cyst in anal canal ☐
   c) Dryness in anal canal ☐
   d) Swelling in anal canal ☐

10. What are the two main types of anal fissure?

   a) Acute and chronic anal fissure ☐
   b) Mild and moderate anal fissure ☐
   c) Acute and sub acute anal fissure ☐
   d) Primary and secondary anal fissure ☐

11. Which age group anal fissure commonly occurs?

   a) 10-30 years ☐
   b) 31-50 years ☐
   c) 51-70 years ☐
   d) 70 and above ☐

12. Which group commonly getting affected with anal fissure?

a) Children ☐

b) Male adult ☐

c) Female adult ☐

d) Old age ☐

13. What is the most common cause of anal fissure?

a) Vomiting ☐

b) Constipation ☐

c) Dryness ☐

d) Swelling ☐

14. What is the most common sign of anal fissure?

a) Pain and bleeding from anal canal ☐

b) Pain in abdomen and vomiting ☐

c) Backache and difficulty in walking ☐

d) None of the above ☐

15. How can we recognize the patient is having anal fissure?

a) By physical examination ☐

b) Communication ☐

c) History collection ☐

d) All of the above ☐

16. What other problems anal fissure can cause?

a) Infection in abdomen ☐

b) Abscess (pus) formation in anal canal ☐

c) Skin infection ☐

d) Itching ☐

17. When does anal fissure client experiences pain in anal canal?

a) During walk ☐

b) Time of defecation (passing stool) ☐

c) Urination ☐

d) Coughing ☐

18. How can anal fissure be relieved?

a) Avoiding constipation ☐

b) Using tub (warm) bath on anal region ☐

c) Muscle relaxant ☐

d) All of the above ☐

19. What is the main objective of lifestyle changes?

a) To relieve discomfort and promote healing ☐

b) To increase standard of living ☐

c) To induce diarrhea ☐

d) To increase sedentary lifestyle ☐

20. What lifestyle changes anal fissure clients has to follow?

a) Behavior changes ☐

b) Communication changes ☐

c) Dietary changes ☐

d) Professional changes ☐

21. How can we relieve pain (anal fissure) ?

a) Using stool softeners ☐

b) Reduce physical activity ☐

c) Increase straining ☐

d) Reduce dietary intake ☐

22. Which diet anal fissure clients have to take?

a) Fat rich diet ☐

b) Fiber rich diet ☐

c) Carbohydrate rich diet ☐

d) Diet rich in salt ☐

23. What type of food anal fissure clients have to take?

a) Fruits and green leafy vegetables ☐

b) Corns and chilies ☐

c) Cheese and butter ☐

d) Meat and beef ☐

24. Which fruits are favorable for anal fissure clients?

a) Apple and pomegranates ☐

b) Banana and guava ☐

c) Banana and watermelon ☐

d) Guava and pineapple ☐

25. Which type of food items anal fissure clients have to avoid?

a) Yogurt, curd and butter ☐

b) Papaya, strawberry and pineapple ☐

c) Pulses, clove and fennel ☐

d) Pomegranates, pineapple and watermelon ☐

SECTION - III

Knowledge on Practice Questionnaire

Instruction

Read the following questions carefully and tick (✓) the correct most appropriate answer.

S.No.	Questions	Yes	No
1.	Soluble and insoluble fiber rich diet should take daily		
2.	Cheese and heavy greasy sticky food should take daily		
3.	Pulses and cereals, green leafy vegetables are good and rich in natural fibers		
4.	Daily intake of water is 2 liters		
5.	Consume much sugar, colas and other soft drinks		
6.	Patients should avoid corns and chillis		
7.	Recommended walking per day is 30 min		
8.	Stool softeners are laxatives, they stimulates bowel movements		
9.	Bakery items are fast foods		
10.	Straining creates pressure, which open a healing tear		
11.	Anal fissure clients have to avoid coconut water		
12.	The duration of physical activity and exercise per day is 15-30 minutes		
13.	During bowel movements anal fissure clients have to increase straining		
14.	Sitz bath is good for healing fissure		
15.	Eating fruits and vegetables obtain fibers		

SECTION - II

Answers Key

Question No.	Answers	Score
1.	b	1
2.	c	1
3.	a	1
4.	c	1
5.	d	1
6.	b	1
7.	b	1
8.	c	1
9.	a	1
10.	a	1
11.	a	1
12.	b	1
13.	b	1
14.	a	1
15.	b	1
16.	b	1
17.	b	1
18.	a	1
19.	d	1
20.	c	1
21.	a	1
22.	b	1
23.	a	1
24.	c	1
25.	c	1

SECTION - III

Answer Key

S.No.	Answers	Score
1.	Yes	1
2.	No	1
3.	Yes	1
4.	Yes	1
5.	No	1
6.	Yes	1
7.	Yes	1
8.	No	1
9.	Yes	1
10.	Yes	1
11.	No	1
12.	Yes	1
13.	No	1
14.	Yes	1
15.	Yes	1

ð ° F - Ü

º ¬øò£ù «ï˜è£ í ™ ð®õ ‹

MF º ¬ø

H ¡ õ¼‹ M ù£,è¬ ÷ èõ ù ñ£è ð®ˆ ¶ êKò£ù M ¬ ì ¬ ò Ü¼A½œ÷ è † ì ˆ F™ (✓) ªêŒò¾ ‹

ñ£FK â ‡ : _____

1. õ ò ¶ (õ¼ì ƒ èO™)

Ü) 20-30 õ ò ¶ ☐

Ý) 31-40 õ ò ¶ ☐

Þ) 41-50 õ ò ¶ ☐

ß) 51-60 õ ò ¶ ☐

à) 60 õ ò ¶ , ° «ñ™ ☐

2. ð£ L ù ‹

Ü) Ý ‡ ☐

Ý) ª ð ‡ ☐

3. è™M î ° F

Ü) ð®ŠðP¾ Þ ¡ ¬ ñ ☐

Ý) Ý ó ‹ ð è™M ☐

Þ) à ò˜G ¬ ô , è™M ☐

ß) ð † ì Š ð®Š¹ ☐

à) ð † ì ò «ñŸð®Š¹ ☐

4. ª î£N™ î ° F

Ü) « õ ¬ ô J ¡ ¬ ñ ▢

Ý) Üó² « õ ¬ ô ▢

Þ) î Q ò£˜ « õ ¬ ô ▢

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à) ñŸø ¬ õ ▢

5. ª ð£¼ ÷ £ î £ó£ G ¬ ô

Ü) ₹. 5000 , ° ₩ › ▢

Ý) ₹. 5001 - 10,000 ▢

Þ) ₹.10,001 - 20,000 ▢

ß) ₹. 20,001-30,000 ▢

à) ₹. 3000 , ° « ñ™ ▢

6. ° ´ ‹ ð õ ¬ è

Ü) î Q , ° ´ ‹ ð ‹ ▢

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7. F¼ñ í ˆ î ° F

Ü) F¼ñ í ñ£ ù õ ˜ ▢

Ý) F¼ñ í ñ£è£ î õ ˜ ▢

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8. ñ î ‹

Ü) Þ‰¶ ▢

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9. à í ¾ º ¬ø

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Þ) ¬êõ ‹ ñŸø‹ Ü¬êõ ‹ ▢

10. ðö,è õö,è‹

Ü) ¹¬èŠ H®ˆî™ ▢

Ý) ñ¶ Ü¼‰¶î™ ▢

Þ) ¹¬èJ¬ô à†ªè£œÀî™ ▢

ß) ñŸø «ð£¬î ªð£¼†èœ ▢

à) â¶¾I™¬ô ▢

11. à ì Ÿ ð JŸC º ¬ø

Ü) º ¬øò£è F ù º ‹ ▢

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Þ) âŠ«ð£î£õ¶ å¼º ¬ø ▢

ß) «ñŸ ªè£œÀ õF™¬ô ▢

12. ° î Š H ÷ ¬ õ ðŸP Þ î Ÿ ° º ¡ â Šð® «èœM Šð † ´ œ k ˜ èœ

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Þ) ñ¼ ˆ ¶ õ Ý « ô £ ê ¬ ù èœ Í ô ‹ ☐

ß) ² ò Ü Â ð õ ‹ ☐

13. ° ´ ‹ ð ˆ F™ ò £¼ , è £ õ ¶ ° î Š H ÷ ¾ Þ ¼ ‰ î ¶ ‡ ì £?

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ð°F - Ý

M ù£,èœ

MF º ¬ø

H ¡ õ¼‹ M ù£,è¬ ÷ è õ ù ñ£è ð®ˆ¶ êKò£ ù M ¬ ì ¬ ò Ü¼A½œ÷ è † ì ˆF™ (✓) ªêŒò¾‹

1. W›è ‡ ì õŸÁœ â ¶ à í ¾ñ ‡ ì ô à ÁŠ¹?

Ü) CÁcóè‹ ▢

Ý) Þ ¬øŠ¬ð ▢

Þ) Þ î ò‹ ▢

ß) ¸ ¬ó f ó™ ▢

2. W›è ‡ ì õŸÁœ â‰î à ÁŠ¹èœ à í ¾ñ ‡ ì ôˆF™ õ¼‹?

Ý) CÁcóè‹ ▢

Ý) G Î ó£¡ , Í ¬ ÷ , ñ ‡ ¬ ì «ò£´ ▢

Ý) à í ¾, ° ö£Œ, Þ ¬øŠ¬ð, ñŸÁ‹ ° ì™ ▢

ß) è£¶ , Í , °, ª î£ ‡ ¬ ì ▢

3. Þ ¬øŠ¬ð J ¡ ªêò™ â ¡ ù

Ü) à í ¬ õ «ê I ˆ î™ ñŸÁ‹ ªêKñ£ í ‹ ▢

Ý) ¹ óî ˆ ¬ î àŸðˆF ªêŒî™ ▢

Þ) à í ¾ èN õ£, ° î™ ▢

ß) «ñ™ ° PŠH † ì ¬ õ â ¶ ¾‹ A ¬ ì ò£¶ ▢

4. à í ¾ ñ ‡ ì ô ˆ F ¡ º ®¾ â ¶ ?

Ü) ñ ô , ° ì ™ ▢

Ý) Ý ê ù ‹ ▢

Þ) ° ì ™ ▢

ß) ° ì ™ º ¬ ù ▢

5. CÁ ° ì L ¡ c ÷ ‹ â š õ ÷ ¾ ?

Ý) 2 e † ì ˜ ▢

Ý) 3.5 e † ì ˜ ▢

Þ) 6 e † ì ˜ ▢

ß) 4 e † ì ˜ ▢

6. W › è ‡ ì õ Ÿ Áœ à í ¾ ñ ‡ ì ô ˆ F ¡ ¶ ¬ í à Á Š ¹ èœ â ¬ õ ?

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7. Ý ê ù ˆ F ¡ ª ê ò ™ â ¡ ù

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Þ) è N ¬ õ à Ÿ ð ˆ F ª ê Œ î ™ ▢

ß) ñ Ÿ ø ¬ õ ▢

8. à í ¾ ªêPñ£ù ‹, à í ¾ ñ ‡ ì ô ˆ F™ â ƒ ° º ®Aø ¶?

Ü) CÁ ° ì ™ ▢

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Þ) Þ ¬ øŠ ¬ ð ▢

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9. ° î ŠH ÷ ¾ â ¡ ø£™ â ¡ ù?

Ü) Ý ê ù õ£Œ H ÷ ¾ ▢

Ý) ° î è£™ õ£Œ ° î è£™ õ£Œ ▢

Þ) Ý ê ù õ£Œ õ ø † C ▢

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10. ° î ŠH ÷ M ¡ Þ ó ‡ ´ º , Aò õ ¬ èèœ

Ü) b Mó ñŸÁ ‹ c ‡ ì è£ô ° î £Šð ° F ¬ ò „ ▢

Ý) « ôê£ù ñŸÁ ‹ I î ñ£ù ° î £Šð ° F ¬ ò „ ▢

Þ) è ´ ¬ ñò£ù ñŸÁ ‹ ¶ ¬ í è ´ ¬ ñò£ù ° î £Šð ° F ¬ ò „ ▢

ß) º î ¡ ¬ ñ ñŸÁ ‹ Þ ó ‡ ì £ ‹ G ¬ ô ° î £Šð ° F ¬ ò „ ▢

11. ° î ŠH ÷ ¾ â ‰ î õ ¬ è õ ò F ù ¼ , ° ª ð£ ¶ õ£è ãŸð ´ ‹?

Ü) 10 - 30 õ ò ¶ ▢

Ý) 31-50 õ ò ¶ ▢

Þ) 51-70 õ ò ¶ ▢

ß) 70 ñŸÁ ‹ Ü î Ÿ ° « ñ™ ▢

12. â‰î õ ¬è õòF ù˜è À , ° ª ð£ ¶ õ£è ° îŠH ÷ ¾ ãŸð ´ ‹

Ü) ° ö‰ ¬ îèœ ▢

Ý) Þ ÷ ‹ ð¼õ Ý ‡ ▢

Þ) Þ ÷ ‹ ð¼õ ª ð ‡ ▢

ß) õò ¶ º F˜‰î õ˜èœ ▢

13. ° îŠH ÷ M ¡ ª ð£ ¶ õ£ ù «ï£Œ è£ó í ƒ èœ

Ü) õ£‰F ▢

Ý) ñô „C , è™ ▢

Þ) õø †C ▢

ß) i , è ‹ ▢

14. ° îŠH ÷ M ¡ º î ¡ ¬ ñ ÜP ° Pèœ

Ü) õ L ñŸø ‹ Þóˆ îèC¾ Ý ê ù õ£Œ ▢

Ý) õ JŸÁ õ L ñŸÁ ‹ õ£‰F ▢

Þ) ï ì , è Þòô£ ¬ ñ ñŸÁ ‹ H ¡ ð , è õ L ▢

ß) «ñ™ àœ ÷ â ¶ ‹ Þ™ ¬ ô ▢

15. â‰î º ¬ øJ™ ° îŠH ÷ ¬ õ è ‡ ì P õ£Œ

Ü) à ì ™ê£˜‰î «î˜¾ ▢

Ý) â ‡ í ƒ è ¬ ÷ ðóŠ ¹ î™ ▢

Þ) õóô£Á Fó† ´ î™ ▢

ß) «ñŸÃ P ò Ü ¬ ù ˆ ¶ ‹ ▢

16. ° îŠH ÷ õ£™ ãŸð´ ‹ Þ îó Hó„ê ¬ ù èœ

Ü) õ JŸÁ ª î£ŸÁ ☐

Ý) Ý ê ù õ£Œ Y › «è£˜ î™ ☐

Þ) « î£™ ª î£ŸÁ ☐

ß) ÜKŠ ¹ ☐

17. ° îŠH ÷¾ « ï£ò£Oèœ âŠ«ð£¶ õ L ¬ ò à í ˜ õ£˜èœ

Ü) ï ì , ° ‹ «ð£¶ ☐

Ý) ñ ô , è N , ° ‹ «ð£¶ ☐

Þ) CÁ c˜ è N , ° ‹ «ð£¶ ☐

ß) Þ¼ º ‹ «ð£¶ ☐

18. â š õ£Á ° îŠH ÷ M™ Þ¼‰¶ M´ ð´ õ£Œ

Ü) ñ ô „C , è ¬ ô î´ ˆ î™ ☐

Ý) ª õ ‰c˜ ° O ò™ ☐

Þ) î ¬ ê î ÷ ˜ î™ ☐

ß) « ñ™ Ã P »œ ÷ Ü ¬ ù ˆ ¶ ‹ ☐

19. º î ¡ ¬ ñ ò£è è ¬ ì ŠH® , è « õ ‡ ®ò õ£ › ¬ è º ¬ ø ñ£Ÿø ‹

Ü) ï ô l ¡ ¬ ñ ¬ ò c , ° î™ ☐

Ý) õ£ › ï£ ¬ ÷ ÜFŠð´ ˆ ¶ î™ ☐

Þ) õ JŸÁ « ð£ , ¬ è à ‡ ì£ , ° î™ ☐

ß) Ü ¡ ø£ ì õ£ › ¬ è º ¬ ø ¬ ò ÜFèŠð´ ˆ ¶ î™. ☐

20. â‰î õ ¬è õ£› , ¬è º ¬øè¬ ÷ °îŠH÷¾ «ï£ò£Oèœ è¬ ìŠH®,è «õ ‡ ´ ‹

Ü) ° í ïô ñ£Ÿø‹ ▢

Ý) ªêŒF ðóŠ¹ ‹ ñ£Ÿø‹ ▢

Þ) à í ¾º ¬ø ñ£Ÿø‹ ▢

ß) ª î£N™ G¬ô ñ£Ÿø‹ ▢

21. õ L ¬ò âš õ£Á c, ° õ£Œ(° îŠH÷¾)

Ü) ñôˆ¬î ªñ ¡ ò£, ° î™ ▢

Ý) à ì Ÿð JŸC ° ¬øˆî™ ▢

Þ) Ü ¿ ˆîˆ¬î ÜGèñ£, ° î™ ▢

ß) à í ¾ à † ªè£œ À î™ ° ¬øˆî™ ▢

22. ° îŠH÷õ£™ ãŸð´ ‹ Þîó Hó„ê¬ ùèœ

Ü) õ JŸÁ ª î£ŸÁ ▢

Ý) Ýêù õ£Œ Y›«è£˜î™ ▢

Þ) «î£™ ª î£ŸÁ ▢

ß) ÜKŠ¹ ▢

23. ° îŠH÷¾ «ï£ò£Oèœ âŠ«ð£¶ õ L ¬ò à í ˜õ£˜èœ

Ü) ï ì , ° ‹«ð£¶ ▢

Ý) ñô ,èN , ° ‹«ð£¶ ▢

Þ) CÁc˜ èN , ° ‹ «ð£¶ ▢

ß) Þ¼º ‹ «ð£¶ ▢

24. â š õ£Á ° îŠH ÷ M™ Þ¼‰¶ M´ ð´ õ£Œ

Ü) ñ ô „C , è ¬ ô î´ ˆ î™ ▢

Ý) ª õ‰c˜ ° O ò™ ▢

Þ) î ¬ ê î ÷ ˜ î™ ▢

ß) «ñ™ Ã P »œ ÷ Ü ¬ ù ˆ ¶ ‹ ▢

25. º î ¡ ¬ ñ ò£è è ¬ ì ŠH® , è« õ ‡ ®ò õ£ › ¬ è º ¬ ø ñ£Ÿ ø ‹

Ü) ï ô l ¡ ¬ ñ ¬ ò c , ° î™ ▢

Ý) õ£ › ï£ ¬ ÷ Ü F Šð´ ˆ ¶ î™ ▢

Þ) õ J Ÿ Á « ð£ , ¬ è à ‡ ì £ , ° î™ ▢

ß) Ü ¡ ø£ ì õ£ › ¬ è º ¬ ø ¬ ò Ü F è Šð´ ˆ ¶ î™. ▢

ð°F - Þ

MFº¬ø

H¡õ¼‹ Mù£,è¬÷ èõùñ£è ð®ˆ¶ êKò£ù M¬ì¬ò Ü¼A½œ÷ è†ìˆF™ (✓) ªêŒò¾‹

Mù£ â‡	**Mù£,èœ**	**Ý‹**	**Þ™¬ô**
1.	è¬ó»‹ ñŸÁ‹ è¬óò£î ï£Ÿêˆ¶ I°‰î à í¾è¬÷ Fùº‹ â´ˆ¶, ªè£œ÷«õ‡´‹		
2.	ð£ô£¬ì,è†® ñŸÁ‹ èù H²H²Šð£ù à í¾è¬÷ Fùº‹ â´ˆ¶, ªè£œ÷«õ‡´‹		
3.	î£Qò*f*èœ ñŸÁ‹ ð„¬êè£ŒèPèœ ÞòŸ¬è ï£Ÿêˆ¶ I°‰î¬õ		
4.	Fùº‹ Þó‡´ L†ì˜î‡a˜ ð¼è«õ‡´‹		
5.	ê˜,è¬ó ñŸÁ‹ °O˜ð£ù*f*èœ ÜFè Ü÷M™ â´ˆ¶,ªè£œ÷«õ‡´‹		
6.	«ï£ò£Oèœ «ê£÷‹ ñŸÁ‹ è£óñ£ù à í¾è¬÷ îM˜,è«õ‡´‹		
7.	Fùº‹ 30 G I ì*f*èœ ï¬ìŠðJŸC «ñŸªè£œ÷«õ‡´‹		
8.	ñô‹ ªñ¡¬ñò£,Aèœ °ì™ Ü¬ê¬õ É‡´‹		
9.	«ð,èKŠ ªð£¼†èœ â™ô£‹ ¶Kî à í¾èœ		

10.	Ü ¿ ˆ î ‹ è® ù ñ£è Þ¼‰î£™, ° í ñ ¬ ì » ‹ ° îŠH ÷ M™ e ‡ ´ ‹ H ÷¾ ãŸð ì ô£ ‹		
11.	° îŠH ÷¾ àœ ÷ õ˜ èœ Þ ÷ c ¬ ó îM˜ , è« õ ‡ ´ ‹		
12.	F ù º ‹ à ì Ÿð J ŸC 15-30 G I ì ƒ èœ ªêŒò« õ ‡ ´ ‹		
13.	° ì ™ Ü ¬ ê¾ Þ¼ , ° ‹ «ð£ ¶ ° îŠH ÷¾ àœ ÷ õ˜ èœ ñô ‹ èN , è ª ð¼ º òŸC ªêŒò« õ ‡ ´ ‹		
14.	è£ŒèP ñŸÁ ‹ ðö õ ¬ èèœ ï£Ÿê ˆ ¬ î ÜFèK , ° ‹		
15.	C † v ° Oò™ ° îŠH ÷ ¬ õ ° í Šð ´ ˆ ¶ ‹ .		

ð ° F - Ý

M ¬ ì èœ

M ù£ â ‡	M ¬ ì	ñFŠª ð ‡
1.	Ý	1
2.	Þ	1
3.	Ü	1
4.	Þ	1
5.	ß	1
6.	Ý	1
7.	Ý	1
8.	Þ	1
9.	Ü	1
10.	Ü	1
11.	Ü	1
12.	Ý	1
13.	Ý	1
14.	Ü	1
15.	Ý	1
16.	Ý	1
17.	Ý	1
18.	Ü	1
19.	ß	1
20.	Þ	1
21.	Ü	1
22.	b	1
23.	a	1
24.	c	1
25.	c	1

ð ° F - Þ

M ¬ ì èœ

M ù £ â ‡	M ¬ ì	ñ F Š ª ð ‡
1.	Þ ™ ¬ ô	1
2.	Ý ‹	1
3.	Þ ™ ¬ ô	1
4.	Þ ™ ¬ ô	1
5.	Ý ‹	1
6.	Þ ™ ¬ ô	1
7.	Þ ™ ¬ ô	1
8.	Ý ‹	1
9.	Þ ™ ¬ ô	1
10.	Þ ™ ¬ ô	1
11.	Ý ‹	1
12.	Þ ™ ¬ ô	1
13.	Ý ‹	1
14.	Þ ™ ¬ ô	1
15.	Þ ™ ¬ ô	1

A STUDY TO ASSESS THE EFFECTIVENESS OF INFORMATION, EDUCATION AND COMMUNICATION PACKAGE IN TERMS OF KNOWLEDGE AND KNOWLEDGE ON PRACTICE REGARDING LIFESTYLE MODIFICATION AMONG ANAL FISSURE PATIENTS IN ASHWIN HOSPITAL, COIMBATORE

HEALTH EDUCATION

ON

LIFE STYLE MODIFICATION OF ANAL FISSURE

Topic	: Life Style Modification Of Anal Fissure
Group	: Anal fissure patients
Place	: Ashwin Hospital, Coimbatore
Duration	: 45 minute
A.V Aids	: Power Point, Pamphlet
Method of teaching	: Lecture cum Discussion and Demonstration

General Objective

At the end of the teaching programme the patients will gain knowledge regarding anal fissure

Specific Objective

At the end of the Information, Education and communication programme the patients are able to

- introduce the topic
- explain anatomy and physiology
- define anal fissure
- explain causes of anal fissure
- discuss Pathophysiology
- enumerate types of fissure
- discuss sign and symptoms of anal fissure
- enumerate complications of anal fissure
- lifestyle modifications among anal fissure clients

Specific Objective	Content	Teachers Activity
Introduce the topic, explain anatomy & physiology of digestive system	**Anatomy and Physiology of Digestive System** **Introduction** The gastrointestinal tract (GIT) consists of a hollow muscular tube starting from the oral cavity, where food enters the mouth, continuing through the pharynx, oesophagus, stomach and intestines to the rectum and anus, where food is expelled. The digestive system is a group of organs which works together to convert food into energy and basic nutrients to feed the entire body. Food passes through a long tube inside the body known as the alimentary canal or the gastrointestinal tract (GI tract). Food is chewed and travels down the pharynx and through the esophagus Contains the following: ➢ Mouth ▪ Salivary glands ▪ Teeth	L E C T U R I N G

	▪ Tongue ▪ Hard palate ▪ Soft palate ▪ Uvula ▪ Epiglottis ➢ Esophagus ➢ Stomach ➢ Intestine ▪ Small intestine ▪ Large intestine ➢ Rectum ➢ Anus	L E C T U R I N G

Discuss about oral cavity Explain function of esophagus	**Mouth** The oral cavity or mouth is responsible for the intake of food. It is lined by a stratified squamous oral mucosa with keratin covering those areas subject to significant abrasion, such as the tongue, hard palate and roof of the mouth. Mastication refers to the mechanical breakdown of food by chewing and chopping actions of the teeth. The tongue, a strong muscular organ, manipulates the food bolus to come in contact with the teeth. It is also the sensing organ of the mouth for touch, temperature and taste. **Esophagus** The esophagus is a muscular tube of approximately 25cm in length and 2cm in diameter. It extends from the pharynx to the stomach after passing through an opening in the diaphragm. The esophagus functions primarily as a transport medium between compartments.	L E C T U R I N G

	Stomach The stomach is a J shaped bag, located just left of the midline between the oesophagus and small intestine. It is divided into four main regions and has two borders called the greater and lesser curvatures. The fundus is the superior, dilated portion of the stomach. The body is the largest section between the fundus and the curved portion of the J. The stomach can hold up to 1.5 Liters of materials. The functions of the stomach include: ➢ The short-term storage of ingested food. ➢ Chemical digestion of proteins by acids and enzymes. ➢ Stomach acid kills bugs and germs. ➢ Some absorption of substances such as alcohol.	L E C T U R I N G

Explain small intestine	**Small Intestine** The small intestine is composed of the duodenum, jejunum, and ileum. It averages approximately 6m in length. The small intestine is compressed into numerous folds and occupies a large proportion of the abdominal cavity. The duodenum is the proximal C shaped section that curves around the head of the pancreas. The duodenum serves a mixing function as it combines digestive secretions from the pancreas and liver with the contents expelled from the stomach. The start of the jejunum is marked by a sharp bend, the. It is in the jejunum where the majority of digestion and absorption occurs. The final portion, the ileum, is the longest segment and empties into the ceacum. **Large Intestine** The large intestine is horse-shoe shaped and extends around the small intestine like a frame. It consists of the appendix, cecum, ascending, transverse, descending and sigmoid colon, and the rectum. It has a length of approximately 1.5m and a width of 7.5cm.	L E C T U R I N G

Discuss about rectum, anus and accessory organ of digestive system.	**Rectum and Anus** The rectum is the final 15cm of the large intestine. It expands to hold faecal matter before it passes through the anorectal canal to the anus. Thick bands of muscle, known as sphincters, control the passage of feces. **Anus** ➢ External opening of rectum ➢ Expels fecal matter **Accessory Digestive Organs** ➢ Liver ➢ Pancreas ➢ Gall bladder ➢ Appendix	L E C T U R I N G

Introduce the topic anal fissure. Define anal fissure Discuss epidemiology.	**ANAL FISSURE** **Introduction:** Anal fissure is the most common cause of severe anal pain. This term has been derived from the Latin root "Fissura" that means a cleft, sulks, or groove, normal or otherwise. The pain of anal ulcer is intolerable and always disproportionate to the severity of the physical lesion. It may be so severe that patients may avoid defecation for days together until it becomes inevitable. This leads to hardening of the stools, which further tear the anoderm during defecation, setting a vicious cycle. **Definition** An anal fissure is a linear tear/ulcer in the lower half of the anal canal and extends from just below the dentate line to the margin of the anus (anal verge). **Epidemiology** ➢ Young or middle aged adults 30–50 years.	L E C T U R I N G

Explain causes of anal fissure.	➢ Slightly more common in males. **Sex** ➢ Fissure is more common in men than in women. **Men** ➢ Posterior midline: 99% ➢ Anterior midline: 01% **Women** ➢ Posterior midline: 90% ➢ Anterior midline: 10% **Etiology** **Primary Causes** ➢ Constipation	L E C T U R I N G

	➢ Spasm of internal sphincter ➢ When too much skin has been removed during operation for haemorrhoids, anal stenosis may result, in which anal fissure may develop when hard motion passes through such stricture. **Secondary Causes** ➢ Ulcerative colitis ➢ Crohn's disease, ➢ Syphilis ➢ Tuberculosis	L E C T U R I N G
Discuss Pathophysiology.	**Pathophysiology** Constipation/diarrhoea ⬇ Local trauma ⬇	

	Sphincter spasm ⬇ Ischemia ⬇ Chronic ulcer	
Enumerate types of fissure	**Types** **Acute Anal Fissure** ➢ Acute fissure in ano is a tear of the skin of the lower half of the anal canal. **Chronic anal Fissure** ➢ If the acute fissure fails to heal it will gradually develop into a deep undermined ulcer; termed now as chronic fissure. It is a deep canoe shaped ulcer with thick oedematous margins.	L E C T U R I N G

Discuss sign and symptoms of anal fissure	**Clinical Features** ➢ Pain on defecation-sharp, cutting & tearing, discomfort 2-3 hrs ➢ Bleeding -slight ➢ Swelling –large sentinel tag ➢ Discharge and pruritis-soiling of ➢ underclothes ➢ Urinary symptoms –sometimes.	L E C T
Enumerate complications of anal fissure	**Complications** ➢ Infections: Infection in a fissure may lead to fissure abscess formation. ➢ Sentinel tag ➢ Enlarged papilla ➢ Anal contracture	U R I N G

	Diagnosis ➢ History collection ➢ Physical examination: ▪ Pruritus in anal region ▪ Ulcerative colitis ▪ Squamous cell/rectum carcinoma ▪ Crohn's Disease **Management** **Conservative Treatment** : ➢ Avoidance of constipation ➢ Anaesthetic ointment ➢ Anal Dilator ➢ Long acting local Anaesthetics ➢ Analgesics / Muscle relaxant	L E C T U R I N G

	➢ Application of glyceryltrinitrate ➢ Botulinum neurotoxin ➢ Hyperbaric oxygen **Surgical Treatment** ➢ Anal Dilatation ➢ Anal sphincter stretching ➢ Lateral sphincterotomy **LIFESTYLE MODIFICATIONS AMONG ANAL FISSURE CLIENTS** **Introduction** Several lifestyle changes may help relieve discomfort and promote healing of an anal fissure, as well as prevent recurrences: ➢ Diet	

	➢ Oral Fluids ➢ Exercise and physical activity ➢ Avoid straining during bowel movements **Diet** ➢ Include both soluble and insoluble fiber to your daily diet. You need a balance of both. ➢ If you eat fruits and vegetables, you can obtain fibre. ➢ Eliminate processed, refined and fast foods from your diet, or at the very least cut way back. ➢ Also cut back on the amount of meat you eat. ➢ Watch your intake of starchy foods. Consume more apples, pears, watermelons, papaya, grapes, strawberries, pomegranates, rose petals, kiwis, and pineapple. ➢ Rice cooked with cumin should be used. ➢ Pulses and cereals, green leafy vegetables, long gourd, round gourd, pumpkins are all good and rich in natural fiber. ➢ Spices like cumin, cinnamon, fennel, cloves, turmeric, and anise can be added in meals.	L E C T U R I N G

	➢ Avoid taking corns (popcorns). ➢ Avoid taking Chilies in diet. ➢ Don't eat Yogurt, curd, Banana, okra. ➢ Cheese is also not good. Heavy, greasy, sticky food is not recommended. ➢ Avoid cakes, pastries, biscuits, snacks, chips, French fries, burgers and other fast food. ➢ Food which causes constipation and gas should be avoided. **Oral Fluids** ➢ At least 2 litres of water each day. ➢ Fruits and vegetable juice. ➢ Should take Coconut water. ➢ Don't consume much sugar, colas and other soft drinks. ➢ Alcohol has to avoid.	L E C T U R I N G

	Exercise and Physical Activities ➢ Include formal exercise or physical activity at least one hour/day to stimulate peristalsis. ➢ 30 min. Walk per day. ➢ Avoid a sedentary lifestyle. ➢ Don't strain to have a bowel movement. ➢ If necessary you can take an OTC (over the counter) stool softener (decussate) 100 mg for 7 days to assist you while you make the other changes. ➢ Stool softeners aren't laxatives. They don't stimulate bowel movements, they make them easier. **Avoid Straining During Bowel Movements** ➢ Straining creates pressure, which can open a healing tear or cause a new tear. **Things to Remember** ➢ A sitz bath is a warm water bath used for healing or cleansing. You should sit in the bath two to three times a day. The water should cover only your hips and buttocks.	L E C T U R I N G

	Conclusion As anal fissure is common in the persons living sedentary lifestyle, it is necessary to modify lifestyle. Changes in diet & lifestyle will help prevent constipation, and prevent or alleviate fissures, and aid in healing. Fissures can be managed with diet and lifestyle modifications.	

திட்டமிட்ட போதனை முறை

குதப்பிளவின்

சிறப்பு நோக்கம் குறிப்பிட்ட குறிக்கோள்

- தலைப்பினை முன்வைத்து, செரிமான மண்டலத்தின் அமைப்பு மற்றும் செயல்பாடுகளை விவரி
- வாயின் அமைப்பு மற்றும் செயல்பாடுகள் குறித்து கலந்துரையாடுதல்
- உணவுக்குழாயின் செயல்பாடுகளை விவரித்தல்
- சிறுகுடல் பற்றி விவரித்தல்
- மலக்குடல், மலத்துவ்வாரம் மற்றும் செரிமான மண்டலத்திற்கு அடுத்து அமைந்துள்ள இதர செரிமான உறுப்புகளை பற்றி கலந்துரையாடுதல்
- மலத்துவார வெடிப்பு என்ற தலைப்பினை அறிமுகம் செய்தல்
- மலத்துவார வெடிப்பு ஏற்படும் விகிதத்தினை விவரித்தல்
- மலத்துவார வெடிப்பு ஏற்படுதலின் காரணங்களை விவரித்தல்
- நோயின் செயல்பாடு குறித்து கலந்துரையாடுதல்
- மலத்துவார வெடிப்பின் பிரிவுகள் வகைகளை விவரித்தல்
- மலத்துவார வெடிப்பின் அறிகுறிகளை கலந்துரையாடுதல்
- மலத்துவார வெடிப்பின் பின் விளைவுகள் விவரித்தல்

மையக் கருத்து	தொகுப்பு	ஆசிரியரின் செயல்பாடு
தலைப்பினை முன்வைத்து, செரிமான மண்டலத்தின் அமைப்பு மற்றும் செயல்பாடுகளை விவரி	**செரிமான மண்டலத்தின் அமைப்பு மற்றும் செயல்பாடுகள்** **முன்னுரை** செரிமானப் பாதையானது வெற்றிடத்தசையால் ஆனக்குழாய் போன்ற அமைப்பு. இதில் உணவானது வாயில் தொடங்கி, தொண்டைக்குழி, உணவுக்குழாய், இரைப்பை மற்றும் குடல் வழியாய் மலக்குடலினை அடைந்து மலத்துவாரத்தின் வழியாய் மலக்கழிவாக வெளியேற்றப்படுகிறது. செரிமான மண்டலமானது, பல உறுப்புகளை உள்ளடக்கியது. இங்கு உணவானது ஆற்றலாகவும், அடிப்படை உயிர்ச்சத்துக்களாகவும் மாற்றப்பட்டு முழு உடலிற்கும் ஊட்டமளிக்கிறது.உணவானது உடலினுள் அமைந்திருக்கும் நீண்டக்குழாயின் வழியாக கடத்தி செல்லப்படுகிறது. இதுவே உணவுப்பாதை அல்லது செரிமானக்குழாய் என்றழைக்கப்படுகிறது. உணவானது மெல்லப்பட்டு தொண்டை மற்றும் உணவுக்குழாய் வழியாக பயணம்	கற்பித்தல்

	செய்கிறது. இந்த அமைப்பு கீழ்க்கண்ட உறுப்புகளை உள்ளடக்கியது. ➢ **வாய்** - உமிழ்நீர் சுரப்பி - பற்கள் - நாக்கு - கடினமான மேலண்ணம் - மென்மையான மேலண்ணம் - உள்நாக்கு - மூச்சுக்குழல் மூடி ➢ உணவுக்குழாய் ➢ இரைப்பை ➢ குடல் ➢ சிறுகுடல் ➢ பெருங்குடல் ➢ மலக்குடல்	க ற் பி த் த ல்

	➢ மலத்துவாரம் / ஆசனவாய்	
வாயின் அமைப்பு மற்றும் செயல்பாடுகள் குறித்து கலந்துரையாடுதல்	**வாய்** வாயானது உணவை உள்ளெடுக்கும் பணியினைப் புரிகிறது. இது ஸ்எட்ராட்டிபைடு ஸ்குவாமஸ் செல்களால் ஆன கெரட்டீன் கொண்ட மெல்லிய படலத்தால் மூடப்பட்டிருக்கிறது. இந்த மென்படலமானது வாயின் மற்ற உறுப்புகளான நாக்கு, கடினமான மேலண்ணம் மற்றும் வாயின் மேற்கூரையையும் கவர்ந்துள்ளது. பற்களினால் உணவை சிறு துணுக்குகளாகவும், மாவாகவும் அரைக்கப்படும் செயலே மெல்லுதல் அல்லது சுவைத்தல் எனப்படும். நாக்கானது பலமான தசைகளாலான உறுப்பு. இது பற்களால் அரைக்கப்பட்ட உணவை உணவுத்திரளாக மாற்ற உதவுகிறது. இதுவே வாயில் உள்ள உணர்வு உறுப்பு. இது சூடு, தொடுதல் மற்றும் சுவை போன்ற உணர்வுகளை அறிய உதவுகிறது.	க ற் பி த் த ல்
உணவுக்குழாயின் செயல்பாடுகளை	**உணவுக்குழாய்** உணவுக்குழாயானது சுமார், 25 செ.மீ. நீளமும், 2 செ.மீ. அகலமும் கொண்ட	

விவரித்தல்	தசையாலானக் குழாய் அமைப்பு. இது தொண்டைக்குழியில் தொடங்கி, உதரவிதானத்தின் திறப்பு வழியாய் இரைப்பையில் முடிகிறது. உணவுக்குழாயானது அடுத்தடுத்த கட்டங்களுக்கு அதாவது தசைச்சுருக்கங்களுக்கு கடத்தியாக செயல்படுவதில் முதன்மைப் பங்காற்றுகிறது. **இரைப்பை** இரைப்பையானது "J" வடிவ பை போன்ற அமைப்பு. இது உணவுக்குழாய்க்கும், சிறு குடலுக்கும் இடையே நடுக்கோட்டிற்கு சற்று இடது புறமாக அமைந்துள்ளது. இது நான்கு பெரும்பாகங்களாக பிரிக்கப்படுகிறது. மேலும் இது இரண்ட வேறு எல்லைகளாக பெரிய வளைவு மற்றும் சிறிய வளைவு மடிப்பைக் கொண்டது. ஃபண்டஸ்,என்பது இரைப்பையின் அகன்ற மேற்பகுதி. உடல்பகுதியானது ஃபண்டஸிற்கும் "J" போன்ற வளைவிற்கும் இடைப்பட்ட மிகப்பெரிய பகுதி. இரைப்பையினால் 1.5 லிட்டர் அளவுக்கு உணவுப்பொருளை உள்ளடக்க முடியும். இரைப்பையின் செயல்பாடுகளாவன	கற்பித்தல்

	➢ உட்கொள்ளப்பட்ட உணவுப்பொருளைத் தற்காலிகமாக சேர்த்து வைக்க உதவுகிறது. ➢ நொதிகள் மற்றும் அமிலங்களால் புரோட்டீனின் வேதியியல் செரிமானம் அடையச் செய்கிறது. ➢ இரைப்பையின் அமிலம் நுண்ணுயிர்கள் மற்றும் கிருமிகளை கொல்ல உதவுகிறது. ➢ ஆல்கஹால் போன்ற சில பொருள்களையும் உறிஞ்சுகின்றன.	
சிறுகுடல் பற்றி விவரித்தல்	**சிறுகுடல்** ➢ சிறுகுடலானது டியோடினம், ஜீஜீனம் மற்றும் இலியம் ஆகிய பாகங்களை உள்ளடக்கியது. இது சுமார் 6 மீட்டர் நீளமுடையது. ➢ சிறுகுடலானது பல அதிக மடிப்புகளாக அழுத்தப்பட்டு வயிற்றின் பெரும் பகுதியினை அடைத்துக் கொள்கிறது. ➢ டியோடினமானது "C" போன்ற அமைப்பாக கீழ்நோக்கி கணையத்தின் தலைப்பகுதியை சுற்றி வெளி வளைவாக அமைந்துள்ளது. டியோடினமானது கல்லீரல் மற்றும் பித்தப்பையிலிருந்து சுரந்த செரிமான சுரப்பிகளை, இரைப்பையிலிருந்து வெளி வந்த உணவுக்கலவையோடு ஒன்று சேர்க்கும்	க ற் பி த் த ல்

	பணியினைப் புரிகிறது. ➢ ஜீஜீனத்தின் தொடக்கமானது ஒரு கூர்மையான வளைவால் குறிக்கப்படுகிறது. பெரும்பாலான செரிமானம் மற்றும் உறிஞ்சுதல் பணி ஜீஜீனத்திலேயே நடைபெறுகிறது. ➢ இலியமானது சிறுகுடலின் கடைசி நீண்டப்பகுதியாக சீக்கத்தில் சென்று முடிவடைகிறது. **பெருங்குடல்** பெருங்குடலானது குதிரையின் குளம்பு போன்ற அமைப்புஇது சிறுகுடலை சுற்றி ஒரு சட்ட அமைப்பாக நீண்டுள்ளது. பெருங்குடலானது குடல்வால், சீக்கம், மேலேற்ற, கிடைமட்ட, கீழிறக்க மற்றும் மலக்குடல் ஆகியவற்றை உள்ளடக்கியது. இது சுமார் 1.5 மீட்டர் நீளமும், 7.5 செ.மீ. அகலமுமாயிருக்கிறது.	கற்பித்தல்
மலக்குடல், மலத்துவ்வாரம் மற்றும் செரிமான	**மலக்குடல் மற்றும் மலத்துவாரம் / மலக்குடல் மற்றும் ஆசனவாய்:** பெருங்குடலின் கடைசி 15 செ.மீ. உறுப்பே மலக்குடல். இது விரிந்து மலத்தினை மலத்துவாரம் வழியாய் வெளியனுப்புவதற்கு முன் சேர்த்து வைக்க உதவுகிறது.	

மண்டலத்திற்கு அடுத்து அமைந்துள்ள இதர செரிமான உறுப்புகளை பற்றி கலந்துரையாடுதல்	மலக்குடலில் உள்ள தடித்த வளையங்களாலான சுருக்குத்தசை பல வெளியேற்றுதலைக் கட்டுப்படுத்துகிறது. **ஆசனவாய் / மலத்துவாரம்:** ➢ இது மலக்குடலின் வெளித்துவாரமாக அமைந்துள்ளது. ➢ இது மலக்கழிவுகளை வெளியேற்றுகிறது. **அடுத்துள்ள செரிமான உறுப்புகள்** ➢ கல்லீரல் ➢ கணையம் ➢ பித்தப்பை ➢ குடல் வால்	க ற் பி த் த ல்

மலத்துவார வெடிப்பு என்ற தலைப்பினை அறிமுகம் செய்தல்	**ஆசனவாய் வெடிப்பு / மலத்துவார வெடிப்பு** **முன்னுரை** மலத்துவாரத்தில் ஏற்படக்கூடிய தாங்க முடியாத வலிக்கு மலத்துவார வெடிப்பே மிக முக்கியக் காரணமாக அமைந்துள்ளது. ஆங்கிலத்தில் FISSURE என்று குறிக்கப்படும் வெடிப்பு என்ற பொருள் கொண்ட இச்சொல் இலத்தீன் மொழியில் "FISSURA" என்ற வேர் வார்த்தையின் மரூஉ ஆகும். இதற்கு மடிப்புகள், பள்ளங்கள், வளைவுகள் சாதாரணமான அல்லது வேறு வகையில் என்பது பொருள். உடலில் ஏற்படும் மற்றக் காரியங்களை விடவும் மலத்துவாரத்தின் புண்ணும் / காயமும் அதின் வலியும் மிகவும் வேறுபட்டதாகவும், சகிக்க இயலாததுமாகவும் இருக்கும். இது மிகவும் மோசமான நிலையாகக்கூட இருக்கலாம். இதன் காரணமாக மலம் கழித்தல், தவிர்க்க முடியாததாய் ஆகும் வரை நோயாளிகள் மலம் கழிப்பதை தவிர்த்து விடுகின்றனர் இது மலம் அதிக இறுக்கமடையவும் அதினால் மேலும் மலத்துவராத்தின் தோலில்	கற்பித்தல்

	கிழிதல் ஏற்படவும் வழிவகுக்கிறது.	
மலத்துவார வெடிப்பினை வரையறுத்தல்	**வரையறை** மலத்துவார வெடிப்பு என்பது மலத்துவார வழியின் அடிப்பாதிப்பகுதியிலிருந்து, கீழே மலத்துவாரத்தின் எல்லைக்கோடு வரை ஏற்படக்கூடிய நீண்ட காயம் புண் கிழிதல் ஆகும். ➢ வாலிப மற்றும் 30-50 வயதுக்குட்பட்ட நடுத்தரவயதுள்ளவர்கள். ➢ ஆடவர்க்கே சற்று அதிகப் பொதுவாக ஆண்களுக்கே ஏற்படுகிறது.	க ற் பி த் த ல்
மலத்துவார வெடிப்பு ஏற்படும் விகிதத்தினை விவரித்தல்	**பாலினம்** மலத்துவார வெடிப்பு விட பெண்களை விட ஆண்களுக்கே அதிகமாக ஏற்படுகிறது. **ஆண்கள்** ➢ நடுக்கோட்டிற்கு பின்புறம்-99% ➢ நடுக்கோட்டிற்கு பின்புறம்-01%	

மலத்துவார வெடிப்பு ஏற்படுதலின் காரணங்களை விவரித்தல்	**பெண்கள்** ➢ நடுக்கோட்டிற்கு பின்புறம்-90% ➢ நடுக்கோட்டிற்கு பின்புறம்-10% **காரணங்கள்** ➢ முதன்மை நிலைக் காரணங்கள் ▪ மலச்சிக்கல் ▪ உட்புற சுருக்குத்தசை இறுக்கம் ▪ ஏதேனும் முலம் போன்ற அறுவைச் சிகிச்சையின் போது, அதிக அளவிலான தசை நீக்கப்படுவதால் மலத்துவார குறுக்கம் ஏற்படுகின்றது. இதன் வழியே இறுகிய மலக்கழிவு வெளியேற்றப்படும் பொழுது அந்த குறுக்கத்தில் வெடிப்பு ஏற்பட்டு மலத்துவார வெடிப்பை பண்ணுகிறது. ➢ இரண்டாம் நிலைக் காரணங்கள் ▪ புண்ணேற்பட்ட பெருங்குடல் ▪ க்ரோன்ஸ் நோய்	க ற் பி த் த ல்

	▪ சிபிலிஸ்-சிபிலிஸ் ▪ காசநோய்	
நோயின் செயல்பாடு குறித்து கலந்துரையாடுதல்	**நோயின் செயல்பாடு** மலச்சிக்கல்-வயிற்றுப்போக்கு ↓ உள்ளூர் காயம் ↓ சுருக்குத் தசை இறுக்கம் ↓ இரத்த ஓட்டக் குறைவு ↓ நாள்பட்ட புண்	கற்பித்தல்

மலத்துவார வெடிப்பின் பிரிவுகள் வகைகளை விவரித்தல்	**வகைகள்** **(I) தீவிர மலத்துவார வெடிப்பு** மலத்துவார வழியின் கீழ்ப்பாதியில் உள்ள தோலில் ஏற்படும் கீறலே-கிழிதலே மலத்துவார வெடிப்பு எனப்படும். **(II) நாள்பட்ட மலத்துவார வெடிப்பு** ஒருவேளை தீவிர மலத்துவார வெடிப்புக் காயமானது குணமாகாவிட்டால் அது மெதுவாக,ஆழமான காயமாக அதின் கீழுள்ள பாகங்களுக்கு பரவ ஆரம்பித்து விடுகிறது. இதுவே நாள்பட்ட மலத்துவார வெடிப்பு எனப்படும். இது ஆழமான வீக்கமடைந்த எல்லையுடைய குழிபோன்ற காயமாகும்.	கற்பித்தல்
மலத்துவார வெடிப்பின் அறிகுறிகளை கலந்துரையாடுதல்	**அறிகுறிகள்** ➢ மலம் கழிக்கும் போது வலி-2-3 மணி நேரத்திற்கு கூர்மையான, வெட்டுப்பட்ட மற்றும் கிழிதலின் வலியுடன் கூடிய சிரமம். ➢ இலேசான இரத்தக்கசிவு	

	➢ பெரிய முடிச்சுப் போன்ற வீக்கம் ➢ சீழ்ப் போன்ற திரவக்கசிவு- அடியிலுள்ள துணிகள் நனையத்தக்கதான திரவக்கசிவு ➢ சிலநேரம் சிறுநீரக சிக்கல்கள்	
மலத்துவார வெடிப்பின் பின் விளைவுகள் விவரித்தல்	**பின் விளைவுகள்** **நோய் தொற்று** மலத்துவார வெடிப்பில் நோய்த்தொற்று ஏற்பட்டால் அந்த வெடிப்பில் சீழ்ப்பிடிக்கக்கூடும். ➢ பெரிதாக்கப்பட்ட பற்காம்பின் ➢ மலத்துவார குறுக்கம் **கண்டறியும் முறைகள்** ➢ வரலாறு கேட்டறிதல் ➢ முழு உடல் பரிசோதனை ▪ மலத்துவாரப் பகுதியில்சீழ் ஏற்படுதல்	க ற் பி த் த ல்

	▪ புண்ணேற்பட்ட பெருங்குடல் ▪ ஸ்குவாமஸ் செல் - மலக்குடல் ▪ புற்றுநோய். ▪ க்ரான்ஸ் நோய். **சிகிச்சை முறைகள்** **கன்சார்வேடிவ் வேர்ச்சொல்** ➢ மலச்சிக்கலை தவிர்த்தல் ➢ மருக்க செய்யும் மருந்து ➢ மலத்துவார விரிவாக்கப் பொருள் ➢ நீண்ட நேரம் செயல்புரியும் மருக்கச் செய்யும் மருந்துகள். ➢ வலிநிவாரணிகள்-தசை இலகுவாக்க மருந்துகள் ➢ கிளிசரின்ட்ரை நைட்ரேட் மருந்தினைபூசுதல்	க ற் பி த் த ல்

	அறுவை சிகிச்சைகள் ➢ மலத்துவார விரிவாக்கம் ➢ மலத்துவார சுருக்குத்தசையின் சரிசெய்தல் ➢ பக்கசுருக்குத்தசையில் ஓட்டையிடுதல் **மலத்துவார வெடிப்பு உள்ள நோயாளிகளுக்கான வாழ்க்கை முறைமாற்றங்கள்** **முன்னுரை** பலவிதமான வாழ்க்கை முறை மாற்றங்கள் மலத்துவார வெடிப்பு குணமாகவும் அதனால் ஏற்படும் சிரமத்தை சரி செய்யவும் திரும்பத் திரும்ப ஏற்படுதலைத் தடுக்கவும் உதவுகிறது. அதுபோன்ற சில வாழ்க்கை முறை மாற்றங்களாவன ➢ உணவு முறை ➢ திரவம் அருந்துதல் ➢ உடற்பயிற்சி மற்றும் உடல் வேலைபாடுகள் ➢ மலம் கழித்தலின் போது சிரமத்தைத் தவிர்த்தல்.	க ற் பி த் த ல்

	உணவு முறை ➢ உங்களது உடலுக்கு கரையக் கூடிய மற்றும் கலையாத நார்ச்சத்து தேவை என்பதால் இவற்றை அன்றாட உணவில் சேர்த்துக் கொள்ளுதலு அவசியம். ➢ உங்களது அன்றாட உணவில் காய்கறிகள் மற்றும் பழங்களை சேர்த்துக் கொள்வதன் முலம் தங்களது உடலுக்குத் தேவையான நார்ச்சத்து பெறப்படுகிறது. ➢ பதப்படுத்தப்பட்ட மற்றும் துரித உணவுகளை தவிர்த்தல் வேண்டும். ➢ தங்கள் அன்றாட உணவுப்பட்டியலில் இறைச்சியின் அளவைக் குறைத்துக் கொள்ளுதல் அவசியம். ➢ தங்கள் உணவில் ஸ்டார்ச்சின் அளவினைக் கணக்கிடுதல் அவசியம். ➢ ஆப்பிள், தர்ப்பூசணி, பயிர், பப்பாளி, திராட்சை, ஸ்ட்ராபெர்ரி,மாதுளை, ரோஜா இதழ்கள், கிவி மற்றும் அண்ணாச்சிப் போன்ற பழ வகைகளை அன்றாடம் உட்கொள்ளுதல் அவசியம். சீரகம் சேர்த்து சமைக்கப்பட்ட சாதத்தினை பயன்படுத்த வேண்டும்.பயறு மற்றும் விதைகள், பச்சைக்காய்கறிகள், சுரைக்காய், பீர்க்கன்காய், பூசணிக்காய் போன்ற உணவுப்பொருட்கள் இயற்கையாகவே நார்ச்சத்து நிறைந்தவை. ➢ சீரகம், ஏலக்காய், பட்டை, இலவங்கம், மஞ்சள், சோம்பு போன்றவைகளை உணவில்	கற்பித்தல்

	சேர்த்துக் கொள்ளலாம். ➢ சோள வகைகளை தவிர்த்தல் வேண்டும். ➢ தயிர், வாழைப்பழம், ஓக்ரா, பாலாடைக்கட்டி போன்றவற்றை உண்ணக்கூடாது. ➢ அதிக எண்ணெய் மற்றும் பசைத்தன்மையுள்ள உணவுகள் உடலுக்கு ஏற்றதல்ல. பாலாடைக்கட்டியும் உடலுக்கு நல்லதல்ல. ➢ துரித உணவுகள், கேக்குகள், பிஸ்கட்டுகள், சிப்ஸ் வகைகள், எண்ணெய் பொருட்கள் போன்றவற்றை தவிர்த்தல் அவசிய **உடற்பயிற்சி மற்றும் உடல் வேலைகள்** ➢ குடல் அலைவு அலைகளை தூண்டக்கூட்டிய சாதாரணரான உடற்பயிற்களை அன்றாட வாழ்வில் குறைந்தபட்சம் நாள் ஒன்றுக்கு ஒரு மணிநேரமாவது பயிற்சி செய்தல் அவசியம் ➢ ஒரு நாளைக்கு குறைந்தது 30 நிமிட நடைப்பயிற்சி ➢ அவசியம் மிகவும் இலகிவான வாழ்க்கை முறையினை தவிர்த்தல் நல்லது. ➢ மிகவும் சிரம்பபட்டு மலம் கழித்தலை தவிர்த்தல் வேண்டும் ஒரு வேளை இதர	கற்பித்தல்

	மாற்றங்கள் செய்தும் பயனில்லாவிட்டால், தேவைப்பட்டால் அளவுக்கு சற்று அதிகமான ➢ மலத்தினை இலகுவாக்கக்கூடிய மருந்துகளை 100மி.கி. அளவுக்கு 7 நாளைக்கு பயன்படுத்திப் பாருங்கள். மலக்கழிவினை லேசானதாக்கி இலகுவான முறையில் வெளியேற்ற பயன்படுகிறது. ➢ மலம் கழிக்கும்போது சிரமத்தை தவிர்த்தல் வேண்டும். ➢ இவ்வாறு சிரமப்படுதல் அழுத்தத்தை அதிகரித்து உண்டுப்பண்ணி குணமாகிய வெடிப்புக் கீறலில் ஒரு வழியை உண்டுப்பண்ணி மேலும் பல புதிய கீழிதல் கீறல் வெடிப்பினை உருவாக்கும **நினைவில் கொள்ள வேண்டியவைகள்** மலத்துவார வெடிப்புக்காயம் குணமாகவும், அந்தப்பகுதியினைசுத்தம் செய்யவும் தங்களை வெதுவெதுப்பான வெந்நீரில் சற்றுநேரம் அமரச்செய்தல் அவசியம். இந்த நீரானது உங்கள் இடுப்பு மற்றும்தொடைப்பகுதியை மட்டும்மூழகச் செய்யும்படி அமருதல் அவசியம்.	க ற் பி த் த ல்

	முடிவுரை மலத்துவார, இலகுவான வாழ்க்கையினை பின்பற்றும் பெருபாலான மக்களிடையே பொதுவாகக் காணப்படுவதால்...., அவர்கள் வாழ்கை முறையில் சில மாற்றங்களை செய்தல் அவசியம் உணவு மற்றும் வாழ்க்கை முறையில் சில மாற்றங்களை செய்வதன் மூலம் நாம் மலச்சிக்கல், மலத்துவார வெடிப்பு மற்றும் அதின் தீவிரம் ஆகியவற்றைத் தவிர்க்கலாம்.மேலும் இச்சில மலத்துவார வெடிப்பு குணமாவதை துரிதப்படுத்தும். ஆகவே, இது போன்ற மாற்றங்கள் மூலம் மலத்துவார வெடிப்பினை சரிசெய்யலாம்.	க ற் பி த் த ல்